INDEX

	Page
Prologue	v
Statement of Purpose and Prior Proceedings	1
Summary of Argument	11
Argument	12
I. Parents Have A Constitutionally Recognized Duty And Right To Secure Appropriate Medical Treatment For A Sick Child.	12
II. The Hospitalization Of An Emotionally Disturbed Child By His Parents Does Not Call For The Overdose Of Procedural Due Process Prescribed By The Court Below.	20
III. A Federal Court Is Without Jurisdiction To Hear And Decide Matters Relating To Custody.	25
Conclusion	27
Appendix	1a
A. Consent to Filing of Amicus Curiae Brief	1a
B. Affidavit of Samuel L. Davis	2a
C. Opinion, *Jobes* v *Michigan*, Case No 74-004-130-DC (Wayne Cty Cir Ct, Mich 1974)	4a
D. Complaint, *Wojciehowski* v *Michigan*, Case No 75-10022 (ED Mich 1975)	29a
E. Answer of Intervenors, *Wojciehowski* v *Michigan*, Case No 75-10022 (ED Mich 1975)	58a
F. Affidavit of Ralph D. Rabinovitch, MD, with attached case summaries	73a
G. Michigan Mental Health Code, Formal Voluntary Admissions Provisions, MSA 14.800 (415)-(420), MCLA 330.1415-.1420	124a

CITATIONS

Cases — Page

Babcock v *Fisk*, 327 Mich 72, 41 NW 2d 479 (1950) 14

Bartley v *Kremens*, 402 F Supp 1039 (ED Pa 1975)..passim

Boone v *Wyman*, 295 F Supp 1143 (SD NY 1969) 27

Cafeteria Workers v *McElroy*, 367 US 886, 6 L Ed 2d 1230, 81 S Ct 1743 (1961) 20

Dortman v *Lester*, 380 Mich 74, 155 NW 2d 827 (1968).. 14

Dunbar v *Dunbar*, 190 US 340, 47 L Ed 1084, 23 S Ct 757 (1902) 14

Ex parte Burrus, 136 US 586, 34 L Ed 500, 10 S Ct 850 (1890) 25

Gagnon v *Scarpelli*, 411 US 788, 36 L Ed 2d 656, 93 S Ct 1956 (1973) 24

Ginsberg v *New York*, 390 US 629, 20 L Ed 195, 88 S Ct 1274 (1968) 13

Goldberg v *Kelly*, 397 US 254, 25 L Ed 2d 287, 90 S Ct 1011 (1970) 24

Herbstman v *Shifton*, 363 Mich 64, 108 NW 2d 869 (1961) 14

In re Gault, 387 US 1, 18 L Ed 2d 527, 87 S Ct 1428 (1967) 21, 22, 24

Jobes v *Michigan*, Case No 74-004-130-DC (Wayne Cty Cir Ct Mich 1974) 5, 6, 16

Magaziner v *Montemuro*, 468 F 2d 782 (CA 3, 1972)..... 26

May v *Anderson*, 345 US 528, 97 L Ed 1221, 73 S Ct 840, (1953) 15

Page

McKeiver v *Pennsylvania*, 403 US 528, 29 L Ed 2d 647, 91 S Ct 1976 (1971) 22

McKinney v *Caball*, 40 Mich App 389, 198 NW 2d 713 (1972) 14

Meyer v *Nebraska*, 262 US 390, 67 L Ed 1042, 43 S Ct 625 (1923) 13, 14, 15

Morrissey v *Brewer*, 408 US 471, 33 L Ed 2d 484, 92 S Ct 2593 (1972) 24

Pierce v *Society of Sisters*, 268 US 510, 535, 69 L Ed 1070, 45 S Ct 571 (1925).....13, 15

Prince v *Massachusetts*, 321 US 158, 88 L Ed 645, 64 S Ct 438 15

Railroad Commission of Texas v *Pullman Co*, 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941) 26

Reist v *Bay Circuit Judge*, 396 Mich 326, 241 NW 2d 55 (1976) 19, 25

Skinner v *Oklahoma*, 316 US 535, 86 L Ed 1655, 62 S Ct 1110 (1942) 15

Stanley v *Illinois*, 405 US 645, 31 L Ed 2d 661, 92 S Ct 1208 (1972) 12

White v *Michigan*, Case No 75-10022 (ED Mich 1975).... 9

Wisconsin v *Yoder*, 406 US 205, 32 L Ed 2d 15, 92 S Ct 1526 (1972) 12

Wojciehowski v *Michigan*, Case No 75-72318 (ED Mich 1975) .....passim

Yakus v *United States*, 321 US 414, 88 L Ed 834, 64 S Ct 190 (1944) 14

	Page
Statutory	
MSA 13.1064(3), MCLA 318.253	14
MSA 14.800 (415) *et seq.*, MCLA 330.1415 *et seq.*	4
MSA 14.800 (746), MCLA 330.1746	9
MSA 14.809 (1), MCLA 330.19a	5
MSA 25.237, MCLA 722.561	14
MSA 25.238, MCLA 722.562	14
MSA 25.244 (3), MCLA 722.3	14
MSA 27A.2913, MCLA 600.2913	14
MSA 28.331, MCLA 750.136	14
MSA 28.358, MCLA 750.161	14
Miscellaneous	
59 Am Jur 2d, Parent and Child, §§15, 59	14
Locke, Treatise of Civil Government, 3450 (Sherman Ed 1937)	13
Prosser, On Torts, Domestic Relations §117 (1964)	14

PROLOGUE

"The democratic faith is this: that the most terribly important things must be left to ordinary men —the mating of the sexes, the rearing of the young, and the laws of the state. This is democracy; and in this I have always believed."

G. K. Chesterton, *Orthodoxy*, 1908.

IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

---

BRIEF FOR THE MICHIGAN ASSOCIATION OF EMOTIONALLY DISTURBED CHILDREN AS AMICUS CURIAE

STATEMENT OF PURPOSE AND PRIOR PROCEEDINGS

I. THE MICHIGAN ASSOCIATION FOR EMOTIONALLY DISTURBED CHILDREN IS AN ADVOCATE FOR MENTALLY ILL CHILDREN, AND TO THAT END FILES THIS BRIEF AMICUS CURIAE IN SUPPORT OF THE POSITION OF THE APPELLANT.

The Michigan Association for Emotionally Disturbed Children (MAEDC) is a non-profit, charitable organization comprising over two thousand parents, professionals and concerned citizens. Its single, unadulterated purpose is to promote the well-being of children suffering emotional and mental illness. To that end, MAEDC files this brief *amicus curiae* in support of the position of the Appellant.[1]

MAEDC was formed in 1957. At that time, there were few separate, public treatment facilities for mentally ill children in Michigan. Mentally ill children were usually hospitalized on adult wards. There were few community alternatives to hospitalization. There were no special education programs for mentally ill children. There were no community-based day treatment services for mentally ill children.

Since 1957, services for mentally ill children in Michigan have been significantly expanded and improved. Funding of public mental health services for children has been increased. Several public, inpatient facilities devoted exclusively to treating emotional disturbance in children have been established. Special education programs for emotionally disturbed children have become part of public school curricula. Community alternatives to hospitalization, such as day treatment and residential facilities, have been greatly augmented. Public awareness and personal awareness (by parents of emotionally disturbed children) that mental illness is a medically treatable sickness rather than a social stigma have been fostered.

Since 1957, Michigan's inpatient population of approximately six hundred mentally ill children has not grown

[1] MAEDC submits this brief *amicus curiae* with the written consent of all parties to the case. See Appendix, *infra*, at p. 1a.

despite an increase in Michigan's overall child population. The average period of hospitalization has been reduced from over two years in 1957 to less than one year in 1976.

MAEDC fought for and helped achieve each of these advancements.[2]

II. IT IS THE BELIEF AND EXPERIENCE OF MAEDC THAT, IF SUSTAINED, THE DECISION OF THE LOWER COURT IN *BARTLEY* v *KREMENS* WOULD SERIOUSLY HARM MENTALLY ILL CHILDREN IN MICHIGAN.

In *Bartley* v *Kremens*, 402 F Supp 1039 (ED Pa 1975), a two-judge majority of the three-judge court found Pennsylvania's statutory and regulatory scheme for voluntary hospitalization of mentally ill children unconstitutional.[3] The majority held that hospitalizing a child for treatment of mental illness upon the application of his parents (and the concurrence of two physicians) violated the constitutional requirement of due process.

The *Bartley* court also prescribed an admission procedure containing the requisite elements of "due process": (1) An initial judicial hearing within seventy-two hours of hospitalization to determine whether there is probable cause to believe that hospitalization is necessary; (2) A full commitment judicial hearing within two weeks of hospitalization; (3) A finding by clear and convincing proof at the full commitment hearing that hospitalization is neces-

[2] See Affidavit of Samuel L. Davis in Appendix, *infra* at p. 2a.

[3] The *Bartley* decision applied to both mentally ill children and retarded children. MAEDC is not directly involved in protecting the interests of retarded children. Therefore, this brief will be limited to an analysis of the issues from the standpoint of mentally ill children.

sary;[4] (4) Appointment of counsel to represent the child at all significant stages of the hospitalization process; (5) Written notice to the child and his attorney stating the time and place of all hearings and the grounds for proposed hospitalization; (6) Presence of the child at all hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Michigan's statutory scheme for the voluntary hospitalization of children is substantially the same as Pennsylvania's combined statutory and regulatory scheme. MSA 14.800 (415) *et seq*, MCLA 330.1415 *et seq*.[5] The Michigan Mental Health Code provides for voluntary hospitalization of a mentally ill child upon his parents' application and the hospital director's determination that the child needs inpatient treatment. A child thirteen years of age or older can object to hospitalization. Additionally, a suitable person can object to any child's hospitalization regardless of the child's age. The hospital must assist the child in submitting his objection to the court. An objection triggers appointment of counsel and an adversary judicial proceeding within seven days to determine the necessity of hospitalization.

[4] The court below did not order a "pre-commitment hearing" because that would discourage parents from making a difficult but necessary decision to hospitalize their child. *Bartley* v *Kremens*, *supra* at 1039. Instead, the court ordered *two* full-blown, adversarial hearings within two weeks of hospitalization. Is the latter any less discouraging than a hearing prior to admission? In either case, parents must "win" a court hearing on their child's insanity in order to secure sustained, inpatient treatment for their child.

[5] The relevant portions of Pennsylvania's statute and regulations are set forth in *Bartley* v *Kremens*, supra at 1041-43. The relevant portions of the Michigan Mental Health Code are set forth in the Appendix, *infra* at 124a.

MAEDC advocated the enactment of the objection provisions in the Michigan Mental Health Code. At the same time, MAEDC advocated the enactment of the voluntary admission provisions which respect the obligation and right of parents to provide for the needs of a mentally ill child without stigmatizing their child as insane in public court records and adversary judicial proceedings.

If sustained, the *Bartley* decision would eliminate voluntary admissions under the Michigan Mental Health Code. MAEDC supports the Appellant in the instant case because it is the belief and experience of MAEDC that such a result would seriously harm mentally ill children in Michigan.

III. LITIGATION INVOLVING HOSPITALIZATION OF MENTALLY ILL CHILDREN IN MICHIGAN WHICH IS RELEVANT TO A REVIEW OF THE DECISION IN *BARTLEY* v *KREMENS*.

During the past two years, MAEDC has participated in two lawsuits challenging the constitutionality of Michigan's statutory scheme for voluntary admissions of mentally ill children.

Clarice Jobes, et al v *Michigan Department of Mental Health, et al*, Case No. 74-004-130 DC (Wayne Cty Cir Ct, MI, 1974) (hereinafter *Jobes* v *Michigan*), is a class action in state court on behalf of all children hospitalized in public mental health facilities pursuant to the voluntary admission provisions of the Michigan Mental Health Code.[6] Michigan Legal Services is counsel for the plaintiffs in

[6] Initially, *Jobes* attacked the voluntary admission provisions of the statutory forerunner to the Michigan Mental Health Code. The Code was enacted while the *Jobes* suit was pending. Voluntary admission under the former statute [MSA 14.809(1), MCLA 330.19a] were substantially the same as under the present Code, except the former statute did not provide for objections to hospitalization.

Jobes. The plaintiffs contend that the due process and equal protection provisions of the United States Constitution mandate that every sick child be accorded the full panoply of criminal due process protections as a prerequisite to hospitalization by his parents. MAEDC intervened in *Jobes* as a defendant because it did not believe that Michigan Legal Services truly spoke for the best interests of mentally ill children. In October of 1974, the court in *Jobes* granted a motion for partial summary judgment by MAEDC and the State defendants. The court found, *inter alia*, that:

> "[T]he judicial relief prayed by plaintiffs would, in virtually every case, result in a minor child acquiring a permanent public record of mental or emotional infirmity. Can one assume that few or no children would look askance at the possibility of such a record—a record which could interfere with the child's opportunity to work at a desirable job or to study in a desirable school or college?
>
> "Can we assume that few or no children would view with alarm the stigma which would possibly arise from a permanent, public record of mental or emotional infirmity? Many children might see the plaintiffs' victory not as a blessing, but as a curse. *One can readily imagine some children saying to the plaintiffs, 'If you want to help us, drop your lawsuit.'* " (Emphasis supplied.)[7]

Since the entry of partial summary judgment in favor of the defendants, the *Jobes* suit has been dormant.

In November of 1975, Michigan Legal Services combined with two sister agencies, Legal Services of Eastern Michigan and Washtenaw County Legal Aid Society, and filed a class action in federal court on behalf of all children

[7] The full Opinion of the Court in *Jobes* v *Michigan* is included in the Appendix, *infra* at p. 4a.

hospitalized in public mental health facilities pursuant to the voluntary admission provisions of the Michigan Mental Health Code. This lawsuit is captioned *Tom Wojciehowski, Next Friend of John Doe, Jr., a minor, on behalf of John Doe, Jr. and all others similarly situated* v *The Director of the Michigan Department of Mental Health, et al*, Case No. 75-72318 (ED Mich 1975) (hereinafter *Wojciehowski* v *Michigan*). The plaintiffs in *Wojciehowski* contend that the due process and equal protection provisions of the United States Constitution mandate that every sick child be accorded the full panoply of criminal due process protections as a prerequisite to hospitalization by his parents.

The posture of the *Wojciehowski* case illuminates a threshold, jurisdictional issue not addressed in *Bartley*.

> CAN A STRANGER TO A FAMILY STOP INPATIENT TREATMENT FOR AN EMOTIONALLY DISTURBED CHILD BY FILING SUIT AS "NEXT FRIEND" OF THE CHILD ABSENT A PRIOR SHOWING IN A STATE COURT OF COMPETENT JURISDICTION THAT THE PARENTS RESPONSIBLE FOR HOSPITALIZING THEIR CHILD ARE UNSUITABLE?

The *Bartley* decision presupposes federal jurisdiction notwithstanding the absence of a prior state court action divesting the parents of their right to custody and control of their child. That supposition, which radically alters traditional concepts of the parent-child relationship, is an important aspect of *Bartley* which MAEDC hopes this Court will consider in reviewing *Bartley*. Accordingly, MAEDC need apprise this Court of the relevant facts in *Wojciehowski* which frame the above-mentioned issue.[8]

[8] The Complaint and the Answer and Affirmative Defenses of the Intervenor/Defendant (the parents of John Doe, Jr.) in *Wojciehowski* v *Michigan* are set forth in the Appendix, *infra* at p. 29a.

The nominal plaintiff in *Wojciehowski,* John Doe, Jr., is eleven years old. He has been an inpatient at York Woods Center for Children for about two-and-a-half years. He was hospitalized pursuant to the voluntary admission provisions of the Michigan Mental Health Code.

John has a long history of severe mental and emotional disturbance. Since about age four, John has manifested: encephalopathy (brain damage); many of the features of an autistic child; borderline retarded intellectual potential and functioning; possible arrested hydrocephaly; psychotic-like behavior; borderline psychotic personality disorder; deep seething rage; an inability to distinguish fantasy from reality; latent schizophrenia; possible childhood schizophrenia; an obsessive preoccupation with death, blood and gore; bizarre and wildly fluctuating relationships with people in his life; compulsive, violent, assaultive behavior; enuresis and encopresis; severe anxiety and withdrawal; echolalia with bizarre and totally inappropriate verbal responses.

Mr. and Mrs. Doe love their son. They hospitalized John because they believed his problems necessitated the sustained, inpatient medical treatment available at York Woods. They reluctantly reached this decision after years of consultation with, and in accordance with the advice of, numerous psychiatrists, physicians, psychologists and other professional personnel trained in the diagnosis and treatment of mental illness.

Mr. and Mrs. Doe have closely supervised their son throughout his hospitalization at York Woods. They have visited their son on a regular, frequent basis and have taken their son from the hospital for family visits at least one day each week. At York Woods, John has made substantial

progress. Mr. and Mrs. Doe hope to remove their son from York Woods in the Summer or Fall of 1976 so that he may live at home while continuing his medical treatment on an outpatient basis.

Mr. Wojciehowski, the "next friend," is a student teacher who visited John periodically at York Woods through a "big brother" program. As "big brother" to John, Mr. Wojciehowski was fully apprised in writing of the procedure whereby any suitable person can object to a child's hospitalization.

In May of 1975, Mr. Wojciehowski distributed confidential and inaccurate information regarding John to unauthorized persons in violation of the Michigan Mental Health Code. *See* MSA 14.800(746), MCLA 330.1746. Accordingly, York Woods terminated Mr. Wojciehowski as a "big brother." In turn, Mr. Wojciehowski and his attorneys brought their lawsuit "on behalf of" John Doe, Jr. This was accomplished by the simple expedient of affixing John Doe, Jr's. name to their complaint.[9]

Mr. and Mrs. Doe did not authorize or consent to the

[9] Prior to filing their complaint, Mr. Wojciehowski and his attorneys unsuccessfully petitioned for the intervention of John Doe, Jr. in *Deborah White* v *The Michigan Department of Mental Health, et al,* Case No. 75-10022 (ED Mich 1975). *White* is yet another class action, by the same legal aid agencies as in *Jobes* and in *Wojciehowski,* challenging the constitutionality of voluntary admissions for children under the Michigan Mental Health Code. In denying the petition to intervene, the Federal District Court noted that embroiling John Doe, Jr. in a complex class action would be adverse to the child's best interests. The court reasoned that John Doe, Jr. was already a member of the putative class in *White.* Further, the court advised Mr. Wojciehowski and his attorneys that they could best serve the interests of John Doe, Jr. and obtain expeditious relief by filing a writ of *habeas corpus* or by filing an objection to hospitalization pursuant to Sec. 417 of the Code. This was in September of 1975. Mr. Wojciehowski and his attorneys ignored the court's advice and filed *Wojciehowski* v *Michigan* in November of 1975.

lawsuit. They did not even know about the lawsuit. They first heard about the lawsuit on a radio broadcast.

One of the attorneys claiming to represent John Doe, Jr. was quoted by a newspaper as saying "as far as we're concerned the parents have nothing to do with it."[10] Mr. and Mrs. Doe disagreed. They wanted their son to continue receiving beneficial medical treatment at York Woods. They did not believe Mr. Wojciehowski and his attorneys shared their parental love and concern for John's best interests. They did not want Mr. Wojciehowski and his attorneys making critical parental and medical decisions regarding treatment of their son's sickness.

The Does are a working class family. Mr. and Mrs. Doe cannot afford private counsel for complex litigation and do not qualify for assistance from the legal aid agencies claiming to represent their son. MAEDC provided Mr. and Mrs. Doe with counsel so that they could intervene as defendants in *Wojciehowski* and protect the nominal plaintiff, their son.

The complaint in *Wojciehowski*, which used John Doe, Jr's actual name, generated a great deal of publicity. The court struck the child's actual name from the pleadings, and substituted a pseudonym, in order to protect the child and his parents from further public stigmatization and embarrassment. The court granted a motion to appoint Mr. Wojciehowski "next friend" of John Doe, Jr., the nominal plaintiff.

The turmoil of the lawsuit, the creation of an *artificial* adversary relationship between John and his parents, and unsuccessful attempts by Mr. Wojciehowski's attorneys to

[10] "Parents Battle Son's Lawsuit," Detroit Free Press, December 14, 1975.

elicit the child's approval for the lawsuit, have intensified John's manifestations of mental illness and retarded his progress.

Presently, the court in *Wojciehowski* is deliberating whether to stay further proceedings pending the decision of the United States Supreme Court in *Bartley* v *Kremens*.

SUMMARY OF ARGUMENT

The decision in *Bartley* v *Kremens*, 402 F Supp 1039 (1975), invites strangers to the family, next friends and court-appointed attorneys, to usurp custody and control of parents over their sick child. Under *Bartley*, "children's spokesmen," who are unrestrained by bonds of love and affection, could meddle in the familial relationship without any due process for parents. The domestic relation of child *and* parents would become child *against* parents. Federal courts are without primary jurisdiction to radically redefine the parent-child relationship which is within the special competence of state courts.

Bartley inverts the constitutionally recognized principle that parents have a duty and right to secure appropriate medical treatment for their sick child. To protect emotionally disturbed children *against* their parents, the court below prescribed a full-blown, adversary proceeding as a condition for hospitalization. Such a mandatory hearing, together with the other "due process" procedures ordered below, would be a forbidding and often insurmountable obstacle to the receipt of necessary medical treatment. If sustained, the predictable effect of the *Bartley* decision will be to deny emotionally disturbed children critically needed inpatient services.

The due process analysis of the *Bartley* court is based

on a misconception of both the sick child's "private interest" and of the "governmental function" involved when parents avail themselves of state resources to secure necessary treatment for an emotionally disturbed child. The "private interest" of a sick child is nurturing parental oversight, not freedom from hospitalization. The "governmental function" of the state is merely to assist parents in fulfilling their duty and right to secure medical treatment for their child. The "due process" procedures prescribed in *Bartley*, which pit parent against child, are unwarranted and without precedent in our democracy.

ARGUMENT

I. PARENTS HAVE A CONSTITUTIONALLY RECOGNIZED DUTY AND RIGHT TO SECURE APPROPRIATE MEDICAL TREATMENT FOR A SICK CHILD.

Parental accountability is the lynchpin of social organization in a democracy. In *Wisconsin* v *Yoder*, 406 US 205, 232, 32 L Ed 2d 15, 92 S Ct 1526 (1972), Chief Justice Burger stated for the majority:

> "The history and culture of Western civilization reflects a strong tradition of parental concern for the nurture and upbringing of their children. The primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."

In *Stanley* v *Illinois*, 405 US 645, 651, 31 L Ed 661, 92 S Ct 1208 (1972), Justice White stated for the majority:

> "The private interest here, that of a man in the children he has raised, undeniably warrants deference and, absent a powerful countervailing interest, protection. It is plain that the interests of a parent in the companionship, care, custody and management of his or her children, 'come[s] to this court

> with a momentum for respect . . .,' *Kovacs* v *Cooper*, 336 US 77, 95, 93 L Ed 513 69 S Ct 448 (1949)."

In *Ginsberg* v *New York*, 390 US 629, 639, 20 L Ed 2d 195, 88 S Ct 1274 (1968), Justice Brennan stated for the majority:

> "[C]onstitutional interpretation has consistently recognized that the parent's claim to authority in their own household to direct the rearing of their children is basic in the structure of our society."

In *Pierce* v *Society of Sisters*, 268 US 510, 535, 69 L Ed 1070, 45 S Ct 571 (1925), Justice McReynolds stated for the court:

> "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right coupled with the high duty to recognize and prepare him for additional obligations."

Voluntary admissions under Pennsylvania and Michigan law are bottomed on the principle of parental accountability. A child is helpless during his formative years. Parents are the presumed *protectors* of their child. Parents, not the state, are the child's primary guardian. Voluntary admissions permit conscientious parents to discharge their responsibility to care for their child.

In a democracy, the state intervenes only when the familial relationship breaks down. *See* Locke, *Treatise of Civil Government*, 3450 (Sherman Edition 1937). Responsibility could have been distributed differently—totalitarian societies have chosen to undermine the family and substitute the state for the parent—but we have rejected that choice. *Cf. Meyer* v *Nebraska*, 262 US 390, 401-02, 67 L Ed 1042, 43 S Ct 625 (1929).

The law has fostered parental accountability to insure the nurturing assistance children need during their formative years. Parents, not the state, must support, maintain

and care for their offspring. *See, e.g.,* MSA 25.244(3), MCLA 722.3; *Dunbar* v *Dunbar,* 190 US 340, 47 L Ed 1084, 23 S Ct 757 (1902); *Babcock* v *Fisk,* 327 Mich 72, 41 NW 2d 479 (1950). Parental responsibility extends to the child's medical needs. *See, e.g., Herbstman* v *Shifton,* 363 Mich 64, 108 NW 2d 869 (1961); 59 Am Jur 2d, Parent and Child, §§15, 59. Parental responsibility includes engendering socially acceptable conduct in their child. Parents are vicariously liable for their child's misbehavior. *See, e.g.,* MSA 27A.2913, MCLA 600.2913; MSA 13.1064(3), MCLA 318.253; *Dortman* v *Lester,* 380 Mich 74, 155 NW 2d 827 (1968); *McKinney* v *Caball,* 40 Mich App 389, 198 NW 2d 713 (1972); *Prosser on Torts* (1964), Domestic Relations, §117. In fact, criminal sanctions have been prescribed to foster parental accountability. *See, e.g.,* MSA 25.237, MCLA 722.561; MSA 25.238, MCLA 722.562; MSA 28.331, MCLA 750.136; MSA 28.358, MCLA 750.161.

The state institutes programs to assist parents, but no arm of the state has ever contrived to eliminate parental accountability. *Cf. Meyer* v *Nebraska, supra* at 402.

The *Bartley* majority acknowledged, in passing, the "presumption" that parents act in the best interest of their child. *Bartley* v *Kremens, supra* at 1047. Then, the court turned the presumption upside down and fashioned an elaborate "due process" system to "safeguard" every child *against* his parents.

Parental accountability for the care and custody of children is a "compelling public interest." *Yakus* v *United States,* 321 US 414, 88 L Ed 834, 64 S Ct 190 (1944). It is "essential,"[11] "cardinal,"[12] a "basic civil right,"[13] and

[11] *Meyer* v *Nebraska,* supra at 399.
[12] *Prince* v *Massachusetts,* 321 US 158, 166, 88 L Ed 645, 64 S Ct 438 (1944).
[13] *Skinner* v *Oklahoma,* 316 US 535, 541, 86 L Ed 1655, 62 S Ct 1110 (1942).

"far more precious than property rights."[14] *Bartley* would replace parental concern with parental *malice* toward emotionally disturbed children. Such a sweeping conclusion should be supported by equally persuasive evidence that parents of emotionally disturbed children are bad parents. The *Bartley* majority made no such findings.[15]

The United States Supreme Court has enforced parents' duty and right to supervise their childs' education. *Meyer* v *Nebraska, supra; Pierce* v *Society of Sisters, supra.* Why should that principle be inverted when treatment for mentally ill children is involved? Indeed, why should *mentally* ill children be denied the nurturing parental supervision allowed physically ill children? If parents can consent to radiation therapy to treat cancer, why can't parents consent to psychotherapy to treat suicidal depression? If parents are not accountable for the *medical* needs of an emotionally disturbed child, are they still accountable for the *non-medical* needs of such child? If parents cannot *admit* their emotionally disturbed child to a hospital, can parents *withdraw* their child from a hospital?

The *Bartley* majority points to "the stigma associated with civil commitment" as a basis for prescribing "due process" strictures which *guarantee* such stigma. *Bartley* v *Kremens, supra* at 1046. Voluntary admissions permit conscientious parents to secure appropriate, inpatient treat-

[14] *May* v *Anderson,* 345 US 528, 533, 97 L Ed 1221, 73 S Ct. 840 (1953).

[15] Indeed, as Judge Broderick noted in his Dissenting Opinion in Bartley, "The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment." *Id,* 1057. See also expert Affidavit of Dr. Ralph D. Rabinovitch included in Appendix, *infra,* at p. 73a.

ment for their child without stigmatizing their child as insane in public court records and adversary court proceedings. Under *Bartley,* voluntary admissions would be eliminated. Every child hospitalized for emotional disturbance would have a public record and judicial determination of his mental infirmity. *Jobes* v *Michigan, supra; Bartley* v *Kremens* (Dissent), *supra,* at 1057.

The *Bartley* majority concluded that parents, as presumptive adversaries of their child, cannot "waive" their child's "right" to "freedom from hospitalization." Instead, every child must have a court-appointed lawyer who *can* waive the child's right to freedom from hospitalization.[16]

How will the lawyer, a stranger to the child, discharge his duty? If he is indifferent, he will rubber stamp the judgment of the parents and the hospital. If he is sensitive to his ethical and legal responsibilities (or greedy for taxpayer subsidization of his legal practice), he will vigorously assert the child's "right" to "freedom from hospitalization" (regardless of the child's need for hospitalization) in full-blown, adversary proceedings, whenever the slightest doubt clouds his uninformed judgment. The child will be the maleficiary of the lawyer's lack of parental and medical knowledge and qualifications, since the child will have an "opportunity" to be traumatized and stigmatized by court proceedings. Finally, cruelly, the parents will be required to prove their child is insane.[17]

---

[16] See the court's Final Order in *Bartley* v *Kremens* in Appendix to Jurisdictional Statement filed with the United States Supreme Court by the Pennsylvania Department of Justice at p. 102a.

[17] The *Bartley* court did not provide court-appointed counsel for the parents, who may themselves be indigent. If the parents prevail "against" their child, will the state pay their costs and attorney fees?

Guaranteed "public stigmatization" would be just one of the evil effects of the *Bartley* decision. Its harshest effect would be to deny emotionally disturbed children and their families desperately needed treatment and services.

The affidavit of expert Dr. Ralph Rabinovitch, which appears in the Appendix, describes real cases which illustrate the predictable effect of mandatory, adversary commitment proceedings.

George was an eleven-year-old with severe school phobia. He had difficulty leaving his house even for brief periods of time. He sat at home day and night. His problems dated back to his early school days. Almost two years of psychotherapy in the community had not helped. Both the school and the community clinic strongly recommended inpatient treatment for George, but it took many months and much supportive assistance before the parents were able to confront George's need for hospitalization and accept that recommendation. In the hospital, George responded rapidly. He was able to return home and to public school in three months and continues to do well. Had George and his parents been required to undergo the ordeal of an adversary court hearing as a condition of hospitalization, George would probably still be at home, by himself day and night.

Joyce was an elective mute. This emotional problem was recognized when Joyce was seven years old. Injatient care was recommended, but for almost five years Joyce's parents were so troubled by fear and anxiety that they could not bring themselves to hospitalize Joyce. For almost five years, Joyce remained at home and mute. Her social adjustment deteriorated. She became withdrawn and depressed. Finally, Joyce was hospitalized by her parents. She responded to treatment. In five months, she returned

to her home and to public school where she is adjusting well, talking comfortably and enjoying life. Had Joyce and her parents been required to undergo the ordeal of an adversary judicial hearing as a condition of hospitalization, Joyce would probably still be an elective mute, withdrawn and depressed.

Would George and Joyce have benefited from their "right" to "due process" and "freedom from hospitalization?"

George and Joyce are typical examples of the clinical reality that many loving parents have great emotional difficulty in accepting and acting upon their child's need for inpatient treatment of emotional disturbance. In some instances, concerned parents plagued with fear and anxiety wait too long. Then, the ultimate tragedy occurs—suicide or homicide.

Poor families, who are most dependent on public assistance for mental health problems, are also most vulnerable to the fears and anxieties which inhibit all parents from seeking and accepting necessary hospitalization for treatment of emotional disturbance in children.

By replacing voluntary admissions with adversary commitment proceedings, *Bartley* would manufacture a forbidding, often insurmountable, obstacle to receipt of critical medical services. Many loving parents, particularly among poor families, would be unwilling to subject their emotionally disturbed child and themselves to the trauma and stigma of adversary judicial commitment proceedings.[18]

[18] The amplified distrust of poor families toward governmental functions, such as public mental health facilities and judicial proceedings, is a social and clinical fact which the judiciary itself has often recognized. *See, e.g., Reist* v *Bay Circuit Judge*, 396 Mich 326, 345, 241 NW 2d 55 (1976) where the Michigan Supreme Court stated:

"'The indigent are frequently the least able to cope with government in its official functions. See Paulsen, *Juvenile Courts, Family Courts, and the Poor Man*, 54 Cal L Rev 694 (1966). The case at bar was routine for the welfare workers and other juvenile court staff. For the indigent mother, however, the entire proceedings were incomprehensible.' *State* v *Jamison*, 251 Or 114, 116-117, 444 P 2d 15, 17 (1968)."

Many sick children, particularly among poor families, would be denied desperately needed inpatient treatment. "Ultimate tradegies" would proliferate.[19]

Voluntary admissions embrace the principle of parental accountability and respect the confidentiality of the child and his family. *Bartley* discards that principle and turns the relationship of parent and child topsy-turvy. It is preposterous to assume that parents, doctors and social workers are engaged in a malevolent conspiracy against children who suffer mental illness. Yet that is precisely what the majority in *Bartley* must have assumed when it ruled that *every* emotionally disturbed child must have a court-appointed lawyer and an adversary hearing to protect the child against his parents, doctors and social workers. That assumption is completely unfounded and at variance with the very social and legal traditions which gave content to the concept of due process.

An "overdose of due process"[20] should not be used to destroy the familial relationship which gives meaning to "due process" in a democracy. All children, including the mentally ill, can best be protected by those persons uniquely suited to love them and to understand their needs—their parents.

[19] Included in the Appendix, *infra* at p. 73a, is the expert Affidavit of Dr. Ralph D. Rabinovitch concerning the reactions of families to hospitalization for mentally ill children, George and Joyce, and the predictable effect of mandatory, adversary commitment hearings.

[20] See Dissenting Opinion of Judge Broderick in *Bartley, supra* at 1054.

II. THE HOSPITALIZATION OF AN EMOTIONALLY DISTURBED CHILD BY HIS PARENTS DOES NOT CALL FOR THE OVERDOSE OF PROCEDURAL DUE PROCESS PRESCRIBED BY THE COURT BELOW IN *BARTLEY* v *KREMENS*.

The *Bartley* majority held that before an emotionally disturbed child can receive sustained, inpatient treatment, there must be a complete adversarial commitment proceeding between the sick child and his parents. To so conclude, the court reasoned that inpatient medical treatment raised a due process issue because hospitalization deprives a child of liberty by the state. That analysis may be valid when the *state* hospitalizes a child; but it is singularly inappropriate when *parents* fulfill their familial duty by hospitalizing their sick child.[21]

In *Cafeteria Workers* v *McElroy*, 367 US 886, 895, 6 L Ed 2d 1230, 81 S Ct 1743 (1961), the United States Supreme Court explained that the proper amount of due process depends upon the "nature" of the "private interest affected" and of the "governmental function involved."

> "The very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation . . . what procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as of the private interest that has been affected by governmental action."

The due process analysis of the *Bartley* majority is based on a misconception of both "the private interest affected"

[21] In effect, *Bartley* would extend the status of emancipation at birth. Children of the Victorian era were "free" at birth. They were given the same right as adults to wander the streets, live in alms houses, work in textile mills, and work in mines. "The New Child: No Kidding," Newsweek, March 4, 1974.

and "the governmental function involved" when parents secure inpatient treatment for their mentally ill child.

A. When Parents Secure Inpatient Treatment For Their Emotionally Disturbed Child, The "Private Interest" Of The Child Lies Within The Framework Of The Parent-Child Relationship.

The *Bartley* majority ignored the fact that the child's interests cannot be determined apart from his parents unless they are neglectful. It substituted an untested fiction for cherished social and legal principles by assuming that lawyers and judges, strangers to the family, are better qualified than parents to protect the best interests of a sick child.

Who would really be heard in the burlesque of "due process" prescribed in *Bartley? Not the child.* The child, burdened with the disabilities of age and illness, is effectively mute whether represented by his parents or by strangers. The *Bartley* decision invites meddling in the parent-child relationship by strangers who, unrestrained by the bonds of family, may themselves be invidiously motivated. *Wojciehowski* v *Michigan, supra,* was started by a "big brother" in retaliation for his discharge. If sustained, *Bartley* would expose the family to forays by strangers whose motives are untested and whose dedication to "their client" arises at best out of ideological conviction rather than personal love and affection.

As already shown, parental custody and care is a constitutionally recognized principle at the heart of our legal and social traditions. *Bartley* discards that principle and pits parent against child.

Bartley's juxtaposition of child against parent is contrary to this Court's teachings in *In re Gault*, 387 US 1, 18

L Ed 2d 527, 87 S Ct 1428 (1967). *Gault*, misunderstood by the majority below, is the Supreme Court's most complete statement on procedural due process for juveniles. That statement consistently treats the interest and rights of parent and child *in tandem* rather than in discord.

In *Gault*, the state had sentenced a fifteen-year-old boy to three year's detention in a home for juvenile delinquents because the boy allegedly had violated an obscure misdemeanor provision of the Arizona Criminal Code. The Supreme Court noted that a minor "cannot be judged by the more exacting standards of maturity" because childhood is a "period of great instability." *Id*, 45. Viewing the state action as an abridgement of "the youth's freedom and his *parents' right to custody*" (*Id*, 34), the Court prescribed due process protections *for a child and his parents* when the child is charged with a crime.

The "*child and his parents*" have a right to written notice of specific charges. *Id*, 35. The "*child and his parents*" have a right to counsel. *Id*, 41. The right to counsel, the Court suggests, might be waived by the parents. *Id*, 42. The child has a privilege against self-incrimination which might be waived, "depending upon the age of the child and the *presence and competence of parents.*" *Id*, 55. Absent waiver of the privilege and a valid confession, the child has a right of confrontation and cross-examination. *Id*, 56-57.

Thus, in the quasi-criminal context of juvenile delinquency, this Court's "judicious balance"[22] *embraces* the fundamental principles of parental custody and consent. In the medical context of treatment for emotionally disturbed children, there is no justification for discarding pa-

[22] See *McKeiver* v *Pennsylvania*, 403 US 528, 545, 29 L Ed 2d 647, 91 S Ct 1976 (1973).

rental accountability for presumptive parental malice. Mentally ill children are not criminals. Mental health hospitals are not jails. Parents are not prosecutors. The child's "private interest" is his fundamental right to nuturing parental oversight.

B. When Parents Secure Inpatient Treatment For Their Emotionally Disturbed Child, The "Governmental Function Involved" Is To Assist Parents In Fulfilling Their Parental Duty.

The *Bartley* majority treats an emotionally disturbed child's hospitalization *by his parents* as a deprivation of the child's liberty *by the state*. In so doing, the court below erred.

The governmental function in voluntary admissions is *not* an impairment of individual rights by the state. Parents, not the state, are primarily responsible for hospitalizing (or not hospitalizing) their child. Parents, not the state, are primarily responsible for continuing (or stopping) hospitalization for their child.

The state's primary function is to provide mental health services and facilities which permit conscientious parents to fulfill their familial responsibility to their sick child. The state licenses and inspects hospitals; it provides doctors, psychologists, social workers, nurses and attendants. It does all this so that parents can secure necessary medical treatment for their child.

The *Bartley* majority regarded parents as presumptively malevolent and totally excluded parents from "due process." It fashioned "due process" hospitalization procedures between the sick child and the state without even mentioning the parents. Treating parents as irrelevant at

best, the court below manufactured an elaborate child-state admission process which *would make* parents irrelevant to, or worse yet, prosecutors of their sick child.

Bartley's dark vision of the child-state equation is not reality in our democracy. Parents are neither presumptively malevolent nor irrelevant. Voluntary admissions under Pennsylvania and Michigan respect the primary and ultimate responsibility of parents to make critical decisions regarding treatment for their sick children. The state merely assists the parents.

The United States Supreme Court has found procedures like those prescribed in *Bartley* necessary only in situations where the state, *in fact, directly* impairs individual rights. *See, e.g., Gagnon* v *Scarpelli*, 411 US 788, 36 L Ed 646, 93 S Ct 1956 (1973) where the state directly revoked an individual's probation; *Morrissey* v *Brewer*, 408 US 471, 33 L Ed 484, 92 S Ct 2593 (1972) where the state directly revoked an individual's parole; *Goldberg* v *Kelly*, 397 US 254, 25 L Ed 287, 90 S Ct 1011 (1970) where the state directly terminated an individual's welfare benefits; *In re Gault, supra*, at 34, where the state directly impaired a "youth's freedom and his parents' right to custody."

No judicial (or legislative) body in this land has ever successfully prescribed such "due process safeguards" against *parents* who are directly discharging their responsibility to their sick child.

III. A FEDERAL COURT IS WITHOUT JURISDICTION TO HEAR AND DECIDE MATTERS RELATING TO CUSTODY.

Wojciehowski v *Michigan, supra*, explictly frames a threshold, jurisdictional issue which is implicit in *Bartley* v *Kremens*. A stranger to the family attacks the hospitalization of a sick child on "constitutional grounds" behind the backs of the parents and against their wishes. A federal district court, without any hearing to determine the question of custody, appoints the stranger "next friend" to the child so that his (i.e. the stranger's) lawsuit can proceed. Without *any process* (due or otherwise), the parents are divested of significant control over their sick child. This Alice In Wonderland procedure is employed to vindicate a "due process" notion from which parental duties and rights are excluded.[23]

Federal courts are not family courts. Our federal system does not ask federal courts to hear cases concerning marriage, death, custody, dependency or neglect. This court has emphasized that fact in *Ex parte Burrus*, 136 US 586, 594, 34 L Ed 500, 105 S Ct 850 (1890):

> "The whole subject of the domestic relations of the husband and wife, parent and child, belongs to the states and not to the laws of the United States. As to the rights to control and possession of [children], . . . it is one in regard to which neither the Congress of the United States nor any authority of the United States has any special jurisdiction."

[23] *Cf. Reist* v *Bay Circuit Judge* 396 Mich 326, 341-42, 241 NW 2d 55 (1976):

> "The interest of parent and child in their mutual support and society are of basic importance in our society and their relationship occupies a basic position in this society's hierarchy of values. Clearly any legal adjustment of their natural rights and obligations affects a fundamental human relationship. The rights at stake are 'protected' and encompassed within the meaning of the term 'liberty' as used in the Due Process Clause.

By what right were John Doe, Jr. in *Wojciehowski* and the child-plaintiffs in *Bartley* drafted from the custody of their parents to serve as "clients" for strangers? This question is at the core of the *Bartley* case.

If parents cannot hospitalize their child in reliance on medical advice, can parents send their child to summer camp, to boarding school, to church? Can any child "threatened" by parental action now tell his parents to talk to his lawyer?

Magaziner v *Montemuro,* 468 F 2d 782 (3rd Cir 1972) focused on many of the issues raised by *Bartley*—"children's rights," procedural due process, and federal jurisdiction over domestic relations. The plaintiffs were children. A state court judge had refused to allow them to be represented by counsel in a custody proceeding between their parents. The children filed suit in federal court under 42 USC §§1981 and 1983. They claimed that the state court judge had violated their constitutional right as "mature children" to representation in a custody proceeding. The federal district court dismissed the case. The Third Circuit noted that the plaintiffs had not used available state remedies such as *habeas corpus* and affirmed. The court based its decision, *inter alia,* on the doctrines of abstention [*Railroad Commission of Texas* v *Pullman Co,* 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941)] and state jurisdiction over domestic relations [*Ex parte Burrus, supra*], reasoning that:

> "At the very least, if the status of 'mature children' confers rights and privileges not possessed by ordinary minors under Pennsylvania law, determination of this issue is a subject for adjudication by the state's judiciary and not for initial determination by the federal courts." *Id,* 786.[24]

The decision in *Bartley* and the proceedings in *Wojciehowski* encourage a new type of kidnapping. Instead of abduction for base purposes (ransom), children could be abducted for "lofty" purposes (to test the constitutionality of the law). If there is a right for custody in the United States, that right exists regardless of the purpose of the stranger to the family. Since the right for custody *does* exist, it can only be disturbed in a proper proceeding in a state court of competent jurisdiction. The federal courts are not within that definition.

CONCLUSION

For the foregoing reasons the judgment of the court below should be reversed.

Respectfully submitted,
MILLER, KLIMIST, COHEN,
MARTENS & SUGERMAN, P.C.
BY: Bruce A. Miller
BY: Samuel C. McKnight
Attorneys for Michigan Association
for Emotionally Disturbed Children
2460 First National Building
Detroit, Michigan 48226
[313] 965-7540

---

[24] See also *Boone* v *Wyman,* 295 F Supp 1143 (SD NY 1969), where a putative father filed a class action in federal court alleging a denial of due process under New York law which allowed a child born out of wedlock to be temporarily committed to a state foster care hospital by the mother. The district court recognized that a parent of a child cannot be deprived of custody without due process. The court stated that to grant the relief requested would be to embroil a federal court in a domestic "tug of war," and cited *Burris* for authority that such matters fall within the exclusive jurisdiction of state courts.

Mental Patient Civil Liberties Project

May 3, 1976

Barry Roth, Esquire
Office of Legal Counsel
Department of Public Welfare
Harrisburg, Pa. 17120

Re: *Kremens* v. *Bartley*

Dear Barry,

Pursuant to our telephone conversation today and your letter of April 29, 1976, I am pleased to consent to the filing of amicus curiae briefs in the Supreme Court of the United States by the following organizations:

American Psychiatric Association
Michigan Association for Emotionally Disturbed Children

The Melmark Home, Inc.; Deveraux Foundation; Woods School

You are authorized to convey this consent to these parties and the Court; since the American Psychiatric Association previously requested my consent, I will also be writing directly to it.

Matters relating to your other requested amicus, and to ours are dealt with in another letter I am sending you this date.

Sincerely,
/s/ David Ferleger
Attorney
cc: N. Watkins

MICHIGAN ASSOCIATION FOR
EMOTIONALLY
DISTURBED
CHILDREN

668 PALLISTER AVENUE • DETROIT, MICHIGAN 48202 • 313/TRINITY 3-3660

PRESIDENT
John G. Brian, Jr.

VICE-PRESIDENTS
Robert L. Brewster
Jack D. Morgan
William L. Saunders

SECRETARY
John M. Mitchell

TREASURER
Mrs. Herbert Schellenberg

DIRECTORS
Myles F. Armour
Dr. William V. Cardwell
Mrs. Donner Cooper
Arthur M. Dagline
Mrs. Joseph Graham
Mrs. Ronald Gremillion
William D. Harrison, M.D.
Benjamin C. Hoisington
Mrs. Russell Hubbard, Jr.
Hugh Loughrie
Mrs. Edna Belle Lucas
Michael A. Magnotta
Harry J. Nederlander
Mrs. Howard W. Nelson
Carl Post
Donna F. Popp
Mrs. D. O. Smith
Mrs. Patricia A. Smith
Roland G. Stanley, Ph.D.
George Stringer
Robert D. Strobel
James S. Swift
Robert Townsend
Mrs. Benjamin Wigler

PROFESSIONAL
ADVISORY COMMITTEE

CHAIRMAN
William C. Morse, Ph.D.

Ara C. Cary, M.S.W.
Clarice Freud, M.S.W.
LaMaurice Gardner, Ph.D.
Albert I. Rabin, Ph.D.
Ralph D. Rabinovitch, M.D.
Fritz Redl, Ph.D.

EXECUTIVE DIRECTOR
Samuel L. Davis

AFFIDAVIT

I, Samuel L. Davis, after first being duly sworn, upon my oath affirm and state that:

I am the Executive Director of the Michigan Association for Emotionally Disturbed Children (MAEDC). I have held this position since 1960.

MAEDC is a Michigan non-profit corporation incorporated under Act No. 327 of the Public Acts of 1931, as amended. It has a membership of approximately 2000 and local chapters throughout the state of Michigan. It is financed in part through United Fund contributions and by dues and private donations. Its purposes, in part, set forth in its Articles of Incorporation are:

> "To promote the welfare of emotionally disturbed children; to promote better understanding of their problems; to provide an opportunity for parents of such children to share their experiences and to support each other in meeting their problems; to encourage, subject to restrictions hereinafter set forth, the extension of present facilities and the provision of new ones, public and private, for the treatment and education of emotionally disturbed children, and for the training of psychiatrists, psychologists, nurses, teachers, social workers, and other professional personnel required for such treatment and education; to establish and maintain such facilities; to inform parents and others of the existence and facilities of clinics, schools, hospitals and institutions which provide treatment and education for emotionally disturbed children, to encourage and support research into the causes and treatment of emotional disturbance in children."

AFFIDAVIT

The facts contained in Part I of the Statement of Purpose concerning MAEDC and the post-1957 developments in treatment and services for mentally ill children in Michigan are true.

/s/ SAMUEL L. DAVIS

Subscribed and sworn to before
me this 7th day of June, 1976.

/s/ CELIA T. BUCHINSKI,
Notary Public
Wayne County, Michigan
My commission expires October 8, 1978

STATE OF MICHIGAN
IN THE CIRCUIT COURT
FOR THE COUNTY OF WAYNE

CLARICE JOBES, on behalf of JANE DOE; a child called X, by her next friend and mother Ms. X, and other children similarly situated who are inpatients in the custody of the State Department of Mental Health; and members of the MEDICAL COMMITTEE FOR HUMAN RIGHTS, Plaintiffs,

v

MICHIGAN DEPARTMENT OF MENTAL HEALTH; E. G. YUDASHKIN, Director, State Department of Mental Health in his official capacity as well as his successors, agents, assignees, and employees in their official capacity; also the Director or Acting Director of LAFAYETTE CLINIC; CLYDE SIMSON, Director, Children's Psychiatric Unit, Lafayette Clinic; L. R. PIGGOTT, D. F. CALDWELL, and D. OBERLEAS, in their official capacity, as well as their agents, assignees, employees and successors at Lafayette Clinic, in their official capacities, Defendants,

and

MICHIGAN ASSOCIATION FOR EMOTIONALLY DISTURBED CHILDREN, and JOHN DOE and MARY DOE, parents of an emotionally disturbed child in a state mental health facility; and the COUNTY OF WAYNE, Intervening Defendants.

JUDGE VICTOR J. BAUM
(No. P-10556)

CIVIL ACTION
No.
74-004130-DC

OPINION

I - PLAINTIFFS' CLAIMS

The plaintiffs make four distinct claims. First, they contend that the constitutional rights of children to due process and equal protection of the law are violated when they are admitted to state mental hospitals, on a "voluntary" basis, with the informed consent of their parents, but without their own informed consent and without a hearing and approval by a court.[1]

Second, the plaintiffs contend that children are being unlawfully subjected to experimentation and research in state mental hospitals which take place without the informed consent of the children, without benefit to the patient, and without judicial approval.

Third, the plaintiffs claim that the Michigan Mental Health Department and certain hospitals operating under its auspices are unlawfully withholding, from public inspection, records and documents related to research and experimentation on children who are patients at such hospitals.

Respecting these three claims concerning children, the plaintiffs say that this is a class suit in which the named plaintiffs[2] assert the rights of other children who are similarly situated, as well as their own.

Fourth, one group of plaintiffs sue as taxpayers to bar expenditures of public funds which result from allegedly unlawful hospitalization of children and unlawful research and experimentation on them in public mental hospitals.

---

[1] See paragraphs 14, 20, 25, and 28 of the plaintiffs' amended "petition/complaint."

[2] The phrase "named plaintiffs" includes those who are described by pseudonyms to protect their anonymity.

II - DESCRIPTION OF PARTIES

Plaintiff, CLARICE JOBES, was appointed by the Juvenile Court of Wayne County to be the attorney for plaintiff, JANE DOE, a seven-year-old ward of the Juvenile Court, who was, for a time, a patient at Lafayette Clinic, a state mental hospital. There, it is alleged that staff physicians sought to subject Jane Doe to medical experiments without her informed consent, without the informed consent of the Juvenile Court, and without a judicial determination, after a hearing, that the benefit to the patient from such experimentation would outweigh the attendant risks and burdens.

Plaintiff, X, is allegedly a nine-year-old child who was a patient, for a time, at Lafayette Clinic, admitted with the consent of her mother, the plaintiff, Ms. X. Allegedly, the consent given by Ms. X for child X's admission was coerced and was in other respects not an informed consent. It is alleged that child X was admitted to Lafayette Clinic without her own informed consent and without court approval.

Also, plaintiffs allege that physicians at Lafayette Clinic sought to subject child X to medical experiments without informed consent from the child and without a judicial determination, after a hearing, that the benefit to child X from the experiment would outweigh the attendant risks and burdens.

The taxpayer-plaintiffs and their theory have already been described.

The original defendants are the Michigan Department of Mental Health, its director, the director of Lafayette Clinic, and certain officials employed by Lafayette Clinic. Lafayette Clinic is a state mental health facility located in the City of Detroit.

Two defendants have intervened: The Michigan Association for Emotionally Disturbed Children and the County of Wayne. The County claims to have a multi-faceted interest in this litigation. It has a statutory obligation to provide for the care of mentally ill persons. It operates the Wayne County General Hospital, which provides inpatient and outpatient psychiatric care. The County has a statutory obligation to fund operations of the Probate Court, the court which would presumably conduct the hearings which would be required in the event the plaintiffs prevail.

The Michigan Association for Emotionally Disturbed Children is a non-profit corporation organized for the purpose of promoting the well-being of emotionally disturbed children and their parents. The Association seeks to have the court validate the practice of "voluntarily" admitting children to state mental hospitals upon the informed consent of parents, with the hospitals' concurrence, but without either the informed consent of the child or a judicial hearing. The Association opposes any decision by this court which would require a judicial or quasi-judicial finding of mental illness as a condition for such admissions.

III - THE PROCEEDINGS

Motions for summary or partial summary judgment have been filed by the plaintiffs, the defendant, Michigan Association for Emotionally Disturbed Children, and the defendant, Michigan Department of Mental Health.

The principal grounds for a full summary judgment of dismissal urged by the Association in its motion, briefs, and oral argument and which will be dealt with in this opinion are that,

1. The plaintiffs' lawsuit is not a proper vehicle for a class action and to treat it as such would de-

prive non-appearing members within the putative class of due process of law.

2. Plaintiffs have failed to state a claim upon which relief can be granted.

3. There is no actual controversy for which a declaratory judgment may be granted.

The defendant, Michigan Department of Mental Health, seeks a partial summary judgment dismissing plaintiffs' claims concerning the admission of children to state mental hospitals on the grounds that with the guaranties of individual rights in the newly enacted Mental Health Code,[3] hospitalization of children in public mental health facilities without their own informed consent, but with the informed consent of their parents, is lawful in all respects, despite absence of statutory provisions for a judicial hearing in advance of hospitalization.

The plaintiffs seek a partial summary judgment respecting their hospital admissions and research and experiment claims on the following grounds:

"1. That there are no disputed issues of fact concerning the admission of children to public mental hospitals and that as a matter of law, regardless of the parents' informed consent to such hospitalization, the constitutional rights of children are violated[4] by their admission or confinement in a state mental hospital without their informed consent and without a judicial hearing.

[3] MCLA 330.19a, et seq.; MSA 14.809(1), et seq., particularly its provisions for notifying children of their rights and affording them a court hearing soon after their admission with right to counsel and jury trial.

[4] — Including the right to due process of law, the right to equal protection of the laws, and the right to be free of cruel and unusual punishment —

"2. That the use of children in mental hospitals for experimentation or research without their informed consent and without judicial approval, following a hearing, violates like constitutional rights of the children."

IV - CLASS SUIT ISSUE

Is the plaintiffs' complaint a proper vehicle for a class suit?

The complaint respecting hospital admissions, research, and access to hospital records, cannot be treated as a class suit for children in general. The named plaintiffs do not fairly insure the adequate representation of all of the members of the class as required by General Court Rule 208 because they are not members of the class whom they purport to represent.

For a class suit, General Court Rule 208 requires that the named plaintiffs will fairly insure the adequate representation of the members of the class. "This means, first of all, that the representatives must be actual members of the class." Honigman and Hawkins, *Michigan Court Rules Annotated* 602 (1962 Ed).

With respect to the claim of unlawful experimentation, the children most affected are children who are now in public mental hospitals.[5] Neither Jane Doe nor child X are presently in such hospitals. Indeed, not a single plaintiff is presently either an inpatient or the parent of an inpatient in any public mental health facility. Thus, there is no plaintiff who is a member of the class purportedly repre-

[5] Plaintiffs describe as a class, *"children held as inpatients in state mental facilities* [underlining added] who have been or may be subjected . . . to medical experimentation without their consent." (Paragraph 13, Complaint)

sented by the plaintiffs — that is, the class of children who are "inpatients in state mental facilities" — the class upon whom this court's decision will have the greatest impact. Because the named plaintiffs are unlike the class for whom they purport to speak in their research and experiment claim and are not themselves members of this class, we cannot assume that the named plaintiffs will fairly and adequately represent the class.

Let us examine the plaintiffs' claim concerning admissions of children to mental hospitals as it relates to the class suit issue. The defendants argue that with the safeguards provided by the new Mental Health Code, admission of a child to a mental hospital without a judicial hearing and without the child's informed consent is lawful if the parents give informed consent. The plaintiffs argue that hospitalization of children with the informed consent of their parents but without either the informed consent of the children or judicial approval is unconstitutional.[6] As the issue is drawn, the class for whom the plaintiffs necessarily seek relief is the class of children hospitalized on the basis of their parents' informed consent but without the child's informed consent and without "judicial or administrative review."

None of the named plaintiffs has ever been a member of this class. Not a single plaintiff is the child of a parent who gave informed consent to the child's hospitalization. The plaintiffs allege that the mother of plaintiff, child X, did not give voluntary or informed consent. The plaintiffs

[6] Paragraph 25 of plaintiffs' amended complaint recites that ". . . children in the subclass have not been confined as mentally ill persons *after judicial or administrative review* but have been subjected to institutionalization *upon the written agreement of their parents or legal guardians* and the receiving state mental health facility." (Emphasis added)

allege that child Jane Doe was a ward of the probate judge, who was "responsible" for her hospitalization. It is not alleged that there was no "judicial or administrative review" before Jane Doe's hospitalization. The Probate Court must have approved of her placement at Lafayette Clinic. Thus, we have no plaintiff who was ever admitted to a public mental health facility with the informed consent of the parent but without "judicial or administrative review." In the case of one child, there was such "review." In the case of the other child, informed parental consent was lacking.

Respecting the plaintiffs' admissions claim, the relief sought for the members of the putative class, who are inpatients in public mental hospitals, is their release from these hospitals. As mentioned earlier, no named plaintiff is presently an inpatient in a state mental hospital. Thus, the named plaintiffs are not members of the class upon whom this court's decision will have the greatest impact.

More to the point, if the plaintiffs get the relief prayed, the judgment would order release from public mental hospitals of all children who are now in such hospitals with their parents' informed consent, but without their own informed consent and without court approval. But there is no named plaintiff child who was ever admitted to a public mental hospital with his parents' informed consent but without either his own or the court's consent. As noted earlier, one of the two named minor plaintiffs entered the hospital without her parents' informed consent. The other minor plaintiff entered with the approval of a probate judge.

With respect to the hospital admissions claim, we are simply without plaintiffs who are, or who have ever been, members of the class for whom they purport to speak: the

class of children admitted to state mental health facilities upon a consensual arrangement between their parents and officials of the public hospital, but without the informed consent of the children and without judicial approval.

This court cannot assume that all members of this class of children purportedly spoken for by the named plaintiffs would be adequately represented by plaintiffs, who are not even actual members of the class for whom they seek to speak.[7]

Regarding the claim concerning access to hospital records, the persons most concerned are children in public mental hospitals who would be subjected to such research and experimentation and their parents. The pertinent class, therefore, is the class of children who are in public mental hospitals and their parents. No named plaintiff is presently either a child in a public mental hospital, or a parent of such a child. Again, we have the situation in which no plaintiff is a member of the class for whom he seeks to speak.

It is no answer to say that the named plaintiffs are represented by brilliant and assiduous lawyers who will ably advocate for the class. Under General Court Rule 208, it is the parties, and not their lawyers, who are pivotal in determining whether the putative class will be adequately represented by the named plaintiffs.

That the law makes the party the touchstone, rather than his lawyer, should surprise no one. The lawyer is a mere agent of the party — or should be. The client, not the lawyer, has ultimate control of the lawsuit. The lawyer

[7] "[T]he representatives ha[ve] to be members of the class represented . . ." Foster, "The Status of Class Action Litigation," *Research Contributions of the American Bar Foundation*, 1974, No. 4, p. 20.

can be hired and fired by the client. A party, who has a zealous, skillful lawyer today, may have a lackadaisical, inept lawyer tomorrow.

The guarantee of adequate representation lies in the similarity between the named plaintiff and the members of the class he purports to represent. Where this similarity exists there is a likelihood of identity of interest between the named plaintiff and the persons for whom the plaintiff claims to speak. The law rests on the common sense observation that self-interest is a strong motivating force. Where the named plaintiff and the members of the putative class are alike, the plaintiff's self-interest is apt to be the same as the self-interest of the class members who will be effectively benefited or bound by the outcome of the case. In this lawsuit, there is lacking such a similarity of interest between the named plaintiffs and the members of the putative class.

For still another distinct reason, the plaintiffs' complaint regarding research and experimentation is not a proper class action. There can be such great variation in the kinds of experimentation and research done in public mental hospitals that one can hardly say that all children who may be subjected to any kind of research or experimentation in public mental hospitals are similarly situated. One can conceive of experiments which are dangerous, and others which are not. The subjects of such different kinds of experimentation are not similarly situated and are hardly in the same class. It would not be right to make a rule in a case involving innocuous or benign experiments which could, as a practical matter, effectively bind or become a precedent applicable to patients who are subjected to experiments of a dangerous nature. Vice versa, it would be wrong to make a rule in a case dealing with a life-

threatening experiment which could bind, or become a precedent applicable to patients who are subjected to wholly safe experiments.

Similarly, the potential benefit to the patient who is the subject of the research may vary case by case. In those situations where the potential danger to the patient from the research is slight and the potential benefit is great, the patient is not in a situation similar to that of the patient for whom the potential benefit is slight and the potential danger great.

We need not and do not reach or decide the question of whether potential benefit to society is to be weighed in the balance. However, if potential benefit to society is relevant, we have one more variable in which a given plaintiff's case could be unlike the cases of other minor children who might be subjected to experiments or research.

Where such potential dissimilarity exists between the putative spokesman and those spoken for, a class suit is improper.

There is still another distinct reason for refusing to treat the plaintiffs' admission claim as a class suit. For a proper class action, the parties who file the complaint must have essentially the same grievance and must want essentially the same relief as the people they represent. If the people they claim to represent are not likely to have essentially the same sense of grievance as the named plaintiffs or are not likely to want essentially the same relief, the complaint is not a proper vehicle for a class suit.

Respecting the plaintiffs' claim that children should not be admitted to mental hospitals upon the sole consent of their parents without a judicial hearing—is there good reason to believe that there are substantial numbers of children, similarly situated, who share the plaintiffs' sense

of being aggrieved and who share the plaintiffs' desire for relief?

The question could be answered affirmatively if the declaration of rights sought by plaintiffs was indubitably a benefit for children. But this is open to debate and cannot be assumed.

The plaintiffs seek, as a prerequisite for the admission of children to public mental hospitals, the informed consent of the children or court approval, after a hearing. If plaintiffs' goal is achieved, it would be necessary in virtually all cases to create a permanent public record of mental or emotional infirmity before a child could be admitted to a public mental hospital for treatment. It is difficult to imagine a situation in which a minor's consent would be so clearly an informed consent that no judicial test would be necessary. Even if the child voluntarily consented, there would have to be a judicial hearing to test the information, understanding and freedom of choice which the child had in arriving at the decision to enter the hospital. If the child did not consent, there would have to be a hearing before a probate judge to determine whether the child should be admitted to a public mental hospital against his or her will.

Under the laws of Michigan as they now stand, such court proceedings would result in a permanent, public record. Thus, the judicial relief prayed by plaintiffs would, in virtually every case, result in a minor child acquiring a permanent public record of mental or emotional infirmity. Can one assume that few or no children would look askance at the possibility of such a record—a record which could interfere with the child's opportunity to work at a desirable job or to study in a desirable school or college? Can we assume that few or no children would view with

alarm the stigma which could possibly arise from a permanent, public record of mental or emotional infirmity? Many children might see the plaintiffs' victory not as a blessing, but as a curse. One can readily imagine some children saying to the plaintiffs, "If you want to help us, drop your lawsuit."

This is not like the suit in which the goal of those filing the complaint is with very great likelihood shared by those for whom the named plaintiff seeks to speak. Such is the case where plaintiff seeks an award of money, or seeks recognition of a right which is very likely to be desired also by those for whom he speaks.

We cannot find that it is more likely than not, that most, or all children, or even a large number of children, share the pseudonymous plaintiffs' sense of grievance and desire for relief. This being the case, the plaintiffs' complaint respecting admission of children to public mental health facilities cannot be treated as a class suit for and on behalf of children in general.

I conclude that the plaintiffs' complaint is not an appropriate vehicle for a class suit with respect to the claims concerning admission of children to state mental health facilities, research and experimentation on such children, and access to the records of state mental health facilities. However, this does not call for a judgment of dismissal. While the named plaintiffs may not represent others, they may speak for themselves.

The proposition is well established that courts should not decide constitutional issues if the case can be fairly resolved without reaching the constitutional questions. Because this court holds that the plaintiffs' complaint is not appropriate for a class action, it is not necessary

to reach or decide whether treatment of this case as a class suit would violate the due process rights of the members of the putative class.

V—THE TAXPAYERS' CLAIM

The Intervening Defendant, Michigan Association for Emotionally Disturbed Children, has moved for a summary judgment dismissing the complaint of the plaintiff-taxpayers. The ground most strongly urged for such summary judgment is that the complaint's prayer for relief does not seek to enjoin any expenditure of public funds.

I know of no appellate decision which requires a prayer for such an injunction in order to maintain a so-called taxpayers' suit and none has been brought to my attention. The statute[8] simply provides:

> "[A]n action to prevent the illegal expenditure of state funds or to test the constitutionality of a statute relating thereto may be brought . . . in the names of at least 5 residents of this state who own property assessed for direct taxation by the county wherein they reside."

The taxpayer-plaintiffs would seem to qualify. The courts have by interpretation added a requirement to the statute. It is that the "taxpayer-plaintiffs" must have a genuine economic stake in the outcome. *Menendez* v *City of Detroit*, 337 Mich 476 (1953); *Thomson* v *City of Dearborn*, 349 Mich 685 (1957); *Baker* v *City of Grand Rapids*, 142 Mich 637 (1906); *Westen* v *City of Allen Park*, 37 Mich App 121 (1971).

Since the only interest on which taxpayers can predicate standing is their economic interest, if victory in the suit

[8] MCLA 600.2041(3)

would not be to their economic advantage, the taxpayers would not have an interest which would give them standing.

In the instant suit, it may well be that the taxpayers will lose by winning. If plaintiffs prevail, court proceedings will be required in virtually every case in which a child is admitted to a public mental hospital. Query whether the cost to the taxpaying public of such litigation would not exceed the public funds saved in the administration of mental hospitals by regulating admissions of children in the manner prayed by the plaintiffs. But the answer depends upon evidence which is not in the record at this stage of the proceedings. Thus, this court cannot rule, at this stage of the proceedings, that the taxpayer-plaintiffs do not have such a genuine economic interest as would give them standing as plaintiffs.

Moreover, the discontinuance of certain experimentation and research in public mental hospitals would appear, *prima facie*, to result in a saving of public funds. The "taxpayer-plaintiffs," therefore, would seem to have an economic interest in preventing such research and experimentation.

I conclude that the taxpayers have standing and have stated a claim upon which relief can be granted. But this does not mean that the taxpayers' claim must be tried along with the children's claim. The taxpayers' claim should be severed from the other claims of the plaintiffs and should be tried separately for the reasons which follow.

The taxpayers' claim and the claims on behalf of the children are misjoined. The taxpayers' claim is so different in nature and inspired by objectives so different from those of the other plaintiffs that the joinder results in a multifariousness of issues and parties. The joinder of the taxpayers' claim with the claims of the other plaintiffs

on behalf of children complicates and confuses the issues. Such joinder does not contribute to the pursuit of justice.

The old common law objection to multifarious pleading is still available, (Callaghan, *Michigan Pleading and Practice*, Sec. 21.34, p 33), although the relief is no longer dismissal. The modern remedy is severance under General Court Rules 203, 206, 207, and 505, that is, the separation of parties and issues, and the provision for separate trials.

Therefore, although the taxpayers' complaint states a claim for which relief may be granted, their claim should be severed from and tried separately from the claims of the other plaintiffs.

Incidentally, it should not be assumed that this judge will try the taxpayers' claim or the other claims. Under the Wayne County Circuit Court practice, only the presiding judge may order the case tried by the judge to whom it was originally assigned, and the presiding judge does not rule until all the parties have been given an opportunity for a hearing.[9]

VI—THE ACTUAL CONTROVERSY ISSUE CONCERNING ADMISSIONS

Plaintiffs' suit is, in essence, a suit for a declaratory judgment governed by General Court Rule 521. General Court Rule 521 is the successor to two statutes. The first declaratory judgment statute was held unconstitutional in 1920 as an attempt to confer non-judicial powers on the judiciary. The Michigan Supreme Court reasoned that the statute called upon courts to dispose of matters which

[9] Habeas corpus hearings are conducted traditionally by the judge who signed the writ. Although this case was started as a petition for a writ of habeas corpus, it is more correctly characterized as a declaratory judgment action and the plaintiffs have so conceded on the record in open court.

were not actual controversies, and which were not, therefore, within the power conferred by the Constitution on the courts. *Anway* v *Grand Rapids Ry Co,* 211 Mich 592.

Subsequently, the Legislature enacted another declaratory judgment statute which was upheld, when Michigan's high court interpreted it as requiring an actual controversy for exercise of the court's declaratory judgment jurisdiction. *Washington-Detroit Theater Co* v *Moore,* 249 Mich 673 (1930). The 1963 General Court Rules replaced the latter statute, which was repealed by the Revised Judicature Act.

The history of declaratory judgments in Michigan makes one point clear: The Courts of Michigan take very seriously the requirement of an actual controversy as a condition precedent to an assertion of the court's jurisdiction to grant declaratory relief. *McLeod* v *McLeod,* 365 Mich 25 (1961); *McMullen* v *Alger,* 339 Mich 175 (1954); *Johnson* v *City of Muskegon Heights,* 330 Mich 631 (1951); *City of Detroit* v *Div 26, Amalgamated Association of St., Elec., Ry. & Motor Coach Employees,* 332 Mich 237 (1952); *City of Flint* v *Consumers Power Co,* 290 Mich 305 (1939); *School District No. 1* v *School District, City of Lansing,* 331 Mich 523 (1951); *Finlayson* v *West Bloomfield Twp,* 320 Mich 350 (1948); *Village of Grosse Pointe Shores* v *Ayres,* 254 Mich 58 (1931); *Washington-Detroit Theater Co* v *Moore,* 249 Mich 673 (1930).

General Court Rule 521.1 provides:

> "In a case of *actual controversy* within its jurisdiction, any circuit court . . . may declare the rights and other legal relations of any interested party seeking a declaratory judgment whether or not other relief is or could be sought or granted." (Underlining added)

The plaintiffs' claim regarding admission of children to public mental hospitals does not satisfy the jurisdictional requirement that there be an actual controversy.

The principal issue which the plaintiffs seek to raise is whether a child who does not give informed consent to his admission to a public mental hospital may be lawfully admitted upon his parents' informed consent, without a court hearing. There is no genuine or actual controversy regarding this issue because there is no child, who is a party in this case, who has ever been admitted to a public mental hospital upon his parents' informed consent, but without his own informed consent and without court approval.

Admittedly, plaintiff, child X, did not have a court hearing before being hospitalized at Lafayette Clinic. However, according to the plaintiffs' allegations, child X was not admitted to Lafayette Clinic with her mother's informed consent but on the basis of her mother's uninformed, coerced consent. (No party to this lawsuit contends that an admission of a child to a public hospital would be lawful without the informed consent of either the child, the parents, or the court).

According to the plaintiffs' allegations, the other child named as a plaintiff, Jane Doe, was a ward of the Probate Court, Juvenile Division. Nowhere do plaintiffs allege that the Probate Court did not determine that its ward, Jane Doe, should enter a public mental hospital. Indeed, paragraph 9 of the complaint alleges that the Juvenile Division of the Probate Court is responsible for the placement of Jane Doe in the Lafayette Clinic. She could not have been admitted to a public mental hospital without a court passing on the matter. One plaintiff child was admitted without her parents' informed censent. The

other child was admitted after a determination by the Probate Court. No minor plaintiff has ever been, personally or directly, a participant in an actual controversy over the admission of a child to a public mental hospital without the child's consent and without court approval, but with the informed consent of the parents and the hospital. And no adult plaintiff is the parent of a child who has ever been an actual participant in such a hospital admission controversy.

In short, in this case there are no parties to a real controversy over admissions without the informed consent of the child and without a judicial determination, but with the informed consent of the parents. Without actual parties to a controversy, there cannot be an actual controversy.

The court is asked to redress a grievance not actually experienced by any of the parties. The court is called upon to resolve a theoretical, academic, or philosophical dispute, but not to decide an actual controversy between live litigants asserting their own experienced grievances. This, a court has no authority to do. *Washington-Detroit Theater Co* v *Moore*, 249 Mich 673.[10]

Another analytical approach, based on the standing of the parties, leads to the same result. A child, like child X, who was admitted to a public mental hospital without informed consent by her parents, has no standing to challenge admission of children based on their parents' informed consent.

A child, such as Jane Doe, who was admitted to a public mental hospital with the approval of a probate judge, has

[10] "That the [Declaratory Judgment] act does not constitute a court a fountain of legal advice . . . is also amply sustained by judicial opinion." *Washington-Detroit Theater Co* v *Moore, supra*, at 673.

no standing to challenge admissions which have not been approved by a probate judge.

Whether we search for an actual controversy or for standing, we cannot find an appropriate basis for asserting the court's declaratory judgment jurisdiction concerning the issue of admissions of children to public mental facilities on the basis of their parents' informed consent, without their own informed consent and without a judicial determination. In connection with such admissions to public mental hospitals, we seem to have lawyers with a burning cause, but without a burnt client. Such abstract, philosophical disputes are for the classroom, and the arena of political debate but not for resolution by the courts. *Johnson* v *City of Muskegon Heights*, 330 Mich 631; *School District No. 1* v *School District, City of Lansing*, 331 Mich 523; *Washington-Detroit Theater Co* v *Moore*, 249 Mich 673.

I conclude as a matter of law that except for the taxpayer-plaintiffs, the plaintiffs do not present an actual controversy concerning the admissions issue, and do not present any parties with standing to raise it. It is not enough to say that somewhere there must be people who are participants in such an actual controversy. The named plaintiffs are not, and they cannot rely on unnamed and unknown people to make an actual controversy.

For these reasons, the court holds that the defendants are entitled to a partial summary judgment of dismissal respecting the plaintiffs' claim of unlawfulness in the admission and hospitalization of minor children in state mental health facilities. This holding is not applicable to the taxpayers' claim which should be severed and dealt with, separately.

VII—THE ACTUAL CONTROVERSY ISSUE CONCERNING RESEARCH

There is a close question as to whether the plaintiffs' research and experimentation claim presents an actual controversy. In declaratory judgment actions, courts have been strict in their avoidance of moot issues.[11] In the case at bar, there is no named plaintiff who is now in a public hospital where he or she is, or might be, the subject of experimentation or reseach. Nevertheless, two or the named plaintiffs were, at one time, patients in public mental hospitals where, it is alleged, staff physicians sought to subject them to experimentation or research without the childrens' informed consent and without prior court approval. The experimentation and research claim differs from the admissions claim. No named plaintiff was ever admitted to a public mental health facility without his or her own informed consent but with the informed consent of a parent or parents. On the other hand, named plaintiffs have allegedly been admitted to such facilities and certain defendants allegedly sought to use them as subjects of research and experiments.

In recent years high appellate court decisions have broadened the latitude which the courts have in deciding whether issues are moot. *US* v *Grant Co,* 345 US 629; *Woodson* v *Dept of Social Services,* 27 Mich App 239 (1970); *Lafayette Dramatic Products, Inc* v *Ferentz,* 305 Mich 193 (1943).

The mere cessation by a defendant of allegedly unlawful conduct does not necessarily render a case moot, absent a showing by the defendant that the disputed activity will never again occur. *US* v *Grant Co,* 345 US 629.

---

[11] See the cases cited, supra, page 19.

In view of the allegation that physicians in public hospitals sought to subject certain children to research and experiments without their informed consent and without court approval, the issue of the lawfulness of such a practice by the personnel of public hospitals is appropriate for judicial resolution even though the children are no longer in such hospitals.

This court holds that the issues raised by the plaintiffs' research and experimentation claim are not moot. Further, this court holds that there is an actual controversy regarding the plaintiffs' research and experimentation claim.

As earlier indicated, the claim of the taxpayer-plaintiffs respecting research and experimentation should be dealt with separately.

VIII—SUMMARY JUDGMENT INAPPROPRIATE ON RESEARCH CLAIM

There are disputed issues of material facts respecting the plaintiffs' experimentation and research claim, and, for this reason, the court cannot determine as a matter of law whether any of the parties should prevail. For this reason summary judgment is inappropriate. Among the disputed issues are the following: Whether certain of the experimentation and research alleged by the plaintiffs has taken place and whether it is likely to take place in the future; whether or not such experimentation involves risks or burdens to the children who are subjected to it; the extent of such risk or burden, if any; whether there is potential benefit to the patient from the alleged research or experimentation; the extent of such potential benefit, if any; whether or not there is potential benefit to the public[12]

---

[12] The court does not decide whether potential benefit to the public is a relevant factor in determining whether the research in question is lawful.

from the alleged research; the extent of such potential benefit, if any; and whether certain procedures are or are not properly characterized as non-therapeutic research.

Thus, this is not a case in which it can be said that there is no genuine issue of material fact and that either the plaintiffs or the defendants are entitled to judgment as a matter of law.

Nor is this a case in which the plaintiffs have failed to plead a case in which relief can be granted. Plaintiffs allege, *inter alia,* that children in public mental health facilities have been subjected by certain of the defendants to research and experimentation without the consent of their parents or persons *in loco parentis,* without the consent of the children, and without the consent of any court; that the consent of the children to such experimentation is never sought by the defendants; that the experimentation to which the children are subjected can be extremely harmful; that the benefit to the children who are the subjects of experimentation is nill or slight; that the possible side effects of such experimentation are not known; that the experiments are of dubious value as a basis for any scientific conclusions.

These allegations state a claim for which relief can be granted. I conclude, therefore, that the plaintiffs' claim regarding research and experimentation withstands the defendants' motion for sumary judgment.

IX—THE RECORDS CLAIM

The plaintiffs' third distinct claim concerns their right to receive records and documents from public mental health facilities relating to medical experimentation and research.

This matter is regulated by statute, (MCLA 24.201; MSA 3.560(101)), which provides:

> "The circuit court for the county in which the agency records are situated may order, on petition of any person, the production of any identifiable material improperly withheld from public inspection and copy." MCLA 24, 223(2); MSA 3.560(123)

Nowhere in the complaint can one find allegations that a request for identifiable material was made by any of the plaintiffs. Such a request is a prerequisite to a cause of action. *Bristol-Meyers Co* v *FPC,* 424 F 2d 935 (DC Cir, 1970); *Citizens for Better Care* v *Dept of Public Health,* 51 Mich App 474 (1974); *Irons* v *Schuyler,* 465 F 2d 609 (DC Cir, 1972).

A partial summary judgment is granted the defendants, dismissing the plaintiffs' claim regarding access to public records, because the plaintiffs' complaint in this regard fails to state a claim on which relief can be granted.

X—CONSTITUTIONALITY OF MENTAL HEALTH CODE

In view of the holding that the plaintiffs' claim concerning admissions to public mental hospitals does not present an actual controversy, this court has no occasion to rule on the constitutionality of the provisions of the new Mental Health Code, which govern admissions of minor children to state mental hospitals and their release.

The defendant, Association, should prepare an order of partial summary judgment in accordance with this opinion, dismissing the plaintiffs' hospital admissions claim for lack of an actual controversy. The order should deny the motion for a partial summary judgment in defendants' favor on the admissions and research claims. It should deny the defendants' motion for summary judgment on the plain-

tiffs' research and experimentation claim. It should dismiss the praecipe for the partial summary judgment motion of the Michigan Department of Mental Health with a finding that there is no occasion to pass upon the constitutionality of the new Mental Health Code in view of the dismissal of plaintiffs' admission claim. The order should provide for a partial summary judgment of dismissal of the plaintiffs' claim concerning access to medical records.

The order should provide for severance and separate trial of the taxpayers' claim.

No costs are to be awarded, no party having wholly prevailed and the issues being close, complex, and novel.

/s/ VICTOR J. BAUM
Circuit Judge

A True Copy
JOSEPH B. SULLIVAN
Clerk
/s/ E. CINSELL
Deputy Clerk

Dated at Detroit, Michigan,
October 29, 1974.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TOM WOJCIEHOWSKI, Next Friend of JOHN DOE, a minor, on behalf of JOHN DOE and all others similarly situated,*

Plaintiffs, No. 75-72318

vs. JUDGE

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health, CORNELIA G. KENNEDY

Defendants.

COMPLAINT FOR INJUNCTIVE, DECLARATORY AND CLASS ACTION RELIEF REQUIRING CONSIDERATION BY A THREE-JUDGE COURT

I. PRELIMINARY STATEMENT

1. Plaintiff, a minor, brings this action on his own behalf and on behalf of all persons in Michigan under 18 years of age who have been, are or will be placed in public mental health facilities under the Formal Voluntary Admissions sections of the new Michigan Mental Health Code,

*This action was originally filed in the name of the nominal plaintiff. The Court amended the title of the case to protect the child and his parents from further public stigmatization and embarrassment. Throughout the complaint, language that identifies the child or his parents has been removed and replaced with three asterisks.

since November 6, 1974, the date the pertinent provisions of said statutes took effect. Plaintiff challenges the constitutionality of those Code sections, MCLA 330.1415-1420, which permitted his parents to have him institutionalized without any showing that he consented to such hospitalization, and without a hearing to determine whether he is mentally ill and dangerous *before* he was committed against his will.

Plaintiff seeks to have the Michigan Statutes allowing parents to hospitalize and treat him against his will enjoined, and declared unconstitutional insofar as they permit the forced hospitalization of persons under 18 years of age without due process or equal protection of the laws as guaranteed by the Fourteenth Amendment to the United States Constitution and as specifically required by the decisions of this Court in *Bell* v *Wayne County General Hospital*, 384 F Supp 1085 (ED Mich 1974) and the decision of the Michigan Courts in *Kaimowitz* v *Department of Mental Health*, Civ. No. 73-19434-AW (Cir Ct of Wayne County, Mich, July 10, 1973).

II. JURISDICTION

2. This is a suit for declaratory and injunctive relief authorized by Title 42 USC §1983 to be commenced by any citizen of the United States, or other persons within the jurisdiction thereof, to redress the deprivation under color of statute, ordinance, regulation, custom or usage of rights, privileges and immunities secured by the Constitution and the law of the United States. The rights, privileges and immunities sought herein to be redressed are those secured by the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the Constitution of the United States.

3. The jurisdiction of this Court is invoked pursuant to Title 28 USC §1343(3) and (4). Injunctive and declaratory relief is requested pursuant to Title 28 USC §2201 and §2202 and as authorized by Tile 42 USC §1983.

4. This is a proper cause for determination by a three-judge court pursuant to Title 28 USC §2281 and §2284, since Plaintiff seeks to enjoin the Defendants and other public officials from the enforcement, operation, application and enactment of state statutes providing for the formal voluntary admission of persons under 18 years of age into a hospital for in-patient treatment of persons who are mentally ill, namely MCLA 330.1415-1420, since the challenged provisions deny such persons as are affected by it rights guaranteed to them under the United States Constitution.

III. PARTIES

5. Plaintiff, * * * , is an 11-year-old citizen of the United States. He currently is incarcerated pursuant to the Formal Voluntary Admission provisions of the Michigan Mental Health Code at York Wood Center for Children at Ypsilanti State Hospital [hereinafter York Wood Center].

6. Plaintiff's next friend, Tom Wojciehowski, is a 24-year-old citizen of the United States, who resides at 788 Watersedge Drive, Ann Arbor, Michigan. Mr. Wojciehowski first became acquainted with Plaintiff when he was employed as a student teacher and child care worker at York Wood Center from August, 1972 through November, 1973. Further, Mr. Wojciehowski, at Plaintiff's parents' request, continued to work with Plaintiff for 5-8 hours per week as Plaintiff's "Big Brother" in a special program at

said York Wood Center from November, 1973 until May, 1975. Mr. Wojciehowski is currently employed as an educational supervisor at Family Group Homes for Youth, Inc., 2500 Packard Road, Ann Arbor, Michigan, and completing his studies for a masters degree at Eastern Michigan University.

7. Defendant, Director of the Michigan Department of Mental Health, has the administrative responsibility for implementing and enforcing the Michigan Mental Health Code; said code includes the statutes in question herein, MCLA 330.1415-1420, which authorize the formal voluntary admission of persons under 18 years of age into hospitals for in-patient treatment as mentally ill persons. Defendant, Director of the Michigan Department of Mental Health, is directly responsible for the operation, administration, and treatment provided to residents of Michigan mental health facilities, including York Wood Center. Donald C. Smith currently occupies this position.

8. Defendant, Vernon Stehman, is the Director of Ypsilanti State Hospital, and an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Stehman is responsible for the operation, administration and treatment provided to residents at Ypsilanti State Hospital, including the York Wood Center for Children.

9. Defendant, William Kirk, is the Director of York Wood Center, and is an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Kirk is responsible for the operation, administration and treatment provided residents at York Wood Center.

10. Defendant, Harvey Day, is Acting Director of In-Patient Services at York Wood Center, and an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Day is responsible for the operation, administration and treatment provided residents who are in-patients at York Wood Center.

IV. CLASS ACTION

11. Plaintiff, * * * , brings this action on behalf of himself and all other persons similarly situated pursuant to Rule 23(a), 23(b)(1) and (b)(2) of the Federal Rules of Civil Procedure. He seeks, on behalf of himself and other members of the class, injunctive and declaratory relief arising from a cause of action under 42 USC §1983.

12. The class consists of all persons under 18 years who have been, now are or will be admitted to hospitals for the in-patient treatment of persons who are mentally ill under the Formal Voluntary Admission sections of the Michigan Mental Health Code, MCLA 330.1415-1420.

13. The persons constituting said class are so numerous that joinder of all members is impracticable.

14. There are questions of law and fact common to the class.

15. The claims of the named Plaintiff are typical of the claims of the class insofar as the members are persons under 18 years of age who are detained under the Formal Voluntary Admission sections of the Michigan Mental Health Code, and as a result are deprived of due process and equal protections of the law as guaranteed to them by

the Fourteenth Amendment to the United States Constitution. The injunctive and declaratory relief Plaintiff seeks is equally applicable to all members of the class.

16. The named Plaintiff will fairly and adequately protect the interests of the class.

17. The prosecution of separate actions by individual members of the class for the purposes stated above would create a risk of: (a) inconsistent or varying determinations with respect to individual members of the class which would establish incompatible standards of conduct for the Michigan Defendants, and (b) determinations with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the other members who would not be parties to the determinations and substantially impede their ability to protect their interests.

18. The Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate preliminary and final injunctive relief and corresponding declaratory relief with respect to the class as a whole.

V. STATEMENT OF FACTS

19. On or about February 25, 1975, Plaintiff's father, * * *, of * * *, Michigan, executed a Formal Voluntary Admission Application as provided in MCLA 330.1415-1420, requesting that Plaintiff herein, his son, be admitted to "Ypsilanti State Hospital—York Wood Center." A copy of said Application is attached hereto and incorporated herein as Plaintiff's Exhibit A.

20. On information and belief, no Court hearing of any kind was held prior to Plaintiff's formal voluntary admission to York Wood Center.

21. On information and belief, Plaintiff objected to his hospitalization at York Wood Center both prior to said formal voluntary admission and subsequent to that date.

22. On or about February 25, 1975, Plaintiff's next friend, Tom Wojciehowski, also received a copy of said Formal Voluntary Admission pursuant to Plaintiff's request and as authorized by MCLA 330.1415-1420. A copy of a letter to Mr. Wojciehowski which accompanied said papers is attached hereto and incorporated herein as Plaintiff's Exhibit B.

23. Mr. Wojciehowski was not informed of his right to object to Plaintiff's incarceration, nor at that time did he consider himself to be an appropriate person to make objections since he had no legal rights to Plaintiff. A copy of the Affidavit of Tom Wojciehowski is attached hereto and incorporated herein as Plaintiff's Exhibit C.

24. Since Plaintiff was not removed from York Wood Center, and Mr. Wojciehowski believed that Plaintiff was neither mentally ill nor dangerous, Mr. Wojciehowski wrote a letter to Defendants Stehman, Kirk and others, detailing his objections to Plaintiff's confinement at York Wood Center. A copy of said letter is attached hereto and incorporated herein as Plaintiff's Exhibit D.

25. As a result of Mr. Wojciehowski's objections to Plaintiff's incarceration, on May 20, 1975, Defendant Day terminated Mr. Wojciehowski's relationship as Plaintiff's "Big Brother;" thus, preventing Mr. Wojciehowski from further communicating with Plaintiff.

26. On or about May 30, 1975, at the request of Mr. Wojciehowski, Attorney Thomas Darnton of Washtenaw

County Legal Aid Society, visited Plaintiff at York Wood Center.

27. During said visit, Plaintiff on several occasions expressed his clear desire to be removed from York Wood Center and indicated his wish that Attorney Darnton aid him. A copy of Attorney Darnton's Affidavit is attached hereto and incorporated herein as Plaintiff's Exhibit E.

28. On or about September 30, 1975, Attorney Rose Marie Adamo of Legal Services of Eastern Michigan, visited Plaintiff at York Wood Center.

29. During said visit, Plaintiff again expressed his clear and continuing desire to be removed from York Wood Center and indicated that he continued to want Attorneys Darnton and Adamo to aid him. A copy of Attorney Adamo's Affidavit is attached hereto and incorporated herein as Plaintiff's Exhibit F.

30. As of this date, despite his objections and those of Mr. Wojciehowski, Plaintiff, * * * , remains incarcerated at York Wood Center and has not received a hearing before any Michigan Court or tribunal where he can contest said confinement.

31. All Defendants have acted under color of their official capacity and the authority they believe they have under the Michigan Mental Health Code and Michigan law to deprive Plaintiff and the class he represents of rights guaranteed to them under the Fourteenth Amendment to the United States Constitution.

VI. EQUITY

32. The Plaintiff, * * * , and the class he represents, have no plain, adequate or complete remedy at

law to redress the stated constitutional deprivations and wrongs; the Plaintiff, and the class he represents, will continue to suffer irreparable harm from the constitutional deprivations and wrongs set forth herein, unless and until the declaratory and injunctive relief sought herein is granted by this Court.

VII. CLAIM

33. Plaintiff realleges herein paragraphs one (1) through thirty-two (32), as set forth above.

34. Plaintiff, * * * , and the members of the class he represents, are currently subjected to incarceration, forced chemotherapy, stigmatizing hospital records and arbitrary transfers in, to and from hospitals for the in-patient treatment of persons who are mentally ill under the Formal Voluntary Admission section of the Michigan Mental Health Code, MCLA 330.1415-1420.

35. Plaintiff, * * * , and the class he represents, are, pursuant to MCLA 330.1415-1420, subjected to said confinement for indefinite lengths of time up to their 18th birthdays and some undetermined period thereafter without judicial hearings prior to or simultaneous with their confinement, to determine:

a. whether they have formally volunteered for admission (i.e., whether they have given informed, knowing and voluntary consent to such incarceration, a determination required by the United States Constitution and court decisions if they were persons over 18 years of age who were formal voluntary admissions to such hospitals as described herein), or

b. whether they are to be involuntarily held as persons who are mentally ill and requiring treatment as defined under the Michigan Mental Health Code.

36. Plaintiff, • • • , and the class he represents, state a cause of action under Title 42 USC §1983 for the deprivation of their civil rights by the named Defendants; said deprivation can only be completely remedied by the enjoining of the enforcement of MCLA 330.1415-1420 and declaring them to be unconstitutional on their face.

37. Said statutes are unconstitutional and deprive Plaintiff and the class he represents of their civil rights insofar as said laws:

a. permit extensive deprivation of liberty of persons under 18 years of age without due process of law;

b. deny equal protection of the law to persons under 18 years of age, as compared to persons over 18 years of age;

c. permit incarceration of such persons under 18 years of age under a standard of "clinical suitability" which is so general, vague, indefinite and overbroad that it does not sufficiently inform those subject to the Formal Voluntary Admission provisions of the Michigan Mental Health Code of the acts or omission which will subject them to in-patient treatment and hospitalization, or provide a meaning which persons of common intelligence can understand and apply equally when they are hospitalizing persons under 18 years of age pursuant to the Michigan Mental Health Code;

d. subject persons to cruel and unusual punishment by stigmatizing them, forcing treatment upon them without any standards or control and institutionalizing them without any determination that they are in fact mentally ill or persons requiring treatment under the Michigan Mental Health Code provisions applicable to persons over 18 years of age;

e. permit invasion of privacy and intrusion into the First Amendment rights of persons under 18 years of age without first providing for judicial determinations that these persons under 18 years of age are in fact mentally ill or persons requiring treatment under the Michigan Mental Health Code provisions applicable to persons over 18 years of age.

VIII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff, • • • , on behalf of himself and the class he represents, prays that this Court:

1st. Assume jurisdiction of this cause and set it down promptly for a hearing pursuant to 28 USC §2284 before a three-judge court, and determination pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure that this cause be maintained as a class action.

2nd. Preliminarily and permanently enjoin the enforcement and operation of MCLA 330.1415-1420 and declare said statutes to be unconstitutional pursuant to Rules 57 and 65 of the Federal Rules of Civil Procedure and Title 82 USC §2201, §2202, §2281 and §2284 so as to prevent the Plaintiff and the class he represents from being incarcerated in hospitals for the in-patient treatment of persons who are mentally ill, subjected to forced chemotherapy, stigmatized by entries on hospital records without prior judicial determinations that they have knowingly and voluntarily consented on an informed basis to such institutionalization or that they are mentally ill and require treatment as defined under the Michigan Mental Health Code.

3rd. Grant Plaintiff, and the members of the class he represents, their costs herein, reasonable attorneys' fees

for their participation in this case in the capacity of private attorney generals, and grant such additional or alternative relief as may be deemed by this Court to be just, equitable and proper.

Respectfully submitted,

Dated: Nov. 24, 1975

/s/Rose Marie Adamo
Attorney for Plaintiff
LEGAL SERVICES OF
EASTERN MICHIGAN
412 Genesee Bank Building
Flint, Michigan 48502
(313) 234-2621

Dated: Nov. 24, 1975

/s/Thomas B. Darnton
Attorney for Plaintiff
WASHTENAW COUNTY
LEGAL AID SOCIETY
130 West Michigan Avenue
Ypsilanti, Michigan 48197
(313) 481-0500

Dated: Nov. 24, 1975

/s/ Gabe Kaimowitz
MICHIGAN LEGAL SERVICES
900 Michigan Building
200 Bagley Avenue
Detroit, Michigan 48226
(313) 964-4130

DMH-2423 EXHIBIT A

MICHIGAN DEPARTMENT
OF MENTAL HEALTH
FORMAL VOLUNTARY ADMISSION APPLICATION

TO: The Director of Ypsilanti State Hospital - York Woods Center

The formal voluntary admission of • • • is requested. The applicant understands that THE HOSPITAL MAY CONTINUE TO HOLD THE INDIVIDUAL UP TO THREE (3) DAYS, NOT INCLUDING SUNDAYS AND HOLIDAYS, AFTER WRITTEN NOTICE OF THE INTENTION TO LEAVE THE HOSPITAL IS GIVEN BY THE PERSON MAKING THIS APPLICATION. THIS WRITTEN NOTICE SHALL BE ON A FORM WHICH WILL BE GIVEN IMMEDIATELY WHEN REQUESTED, OR WHEN THE HOSPITAL IS TOLD OF A DESIRE TO HAVE THE INDIVIDUAL LEAVE THE HOSPITAL.

The applicant also understands that IF THE DECISION TO LEAVE IS NOT CHANGED AND IF THE DIRECTOR OF THE HOSPITAL DECIDES THAT THE PATIENT IS MENTALLY ILL AND, AS A RESULT, THE PATIENT IS LIKELY TO SERIOUSLY PHYSICALLY INJURE HIMSELF OR SOMEONE ELSE OR IS NOT ABLE TO TAKE CARE OF BASIC NEEDS SUCH AS FOOD, CLOTHING OR SHELTER NECESSARY TO AVOID SERIOUS HARM, THE DIRECTOR MAY, WITHIN THREE DAYS, TAKE TO THE PROBATE COURT AN APPLICATION FOR THE CONTINUED HOSPITALIZATION AND TREATMENT OF THE PATIENT, AND THE PATIENT WILL STAY IN THE HOSPITAL PENDING A COURT HEARING.

The applicant understands that the admission is TEMPORARY and that the individual will be released in the community when, in the opinion of the director of the hospital, the individual has made maximum improvement from inpatient care.

The applicant hereby consents to and authorizes the hospital to provide treatment, including medication and chemotherapy, but consent to electroshock, psychosurgery, experimental drugs, and surgical procedures, except surgical and medical procedures of an emergency nature, must be obtained by the hospital in separate consents.

IF THE INDIVIDUAL TO BE ADMITTED IS A MINOR, BOTH THE INDIVIDUAL, IF ABLE TO READ, AND THE APPLICANT MUST READ THE REVERSE SIDE BEFORE SIGNING THE APPLICATION.

The applicant agrees to disclose such information as is required by law to determine financial liability for mental health services. The applicant understands this determination will be made by the Department of Mental Health subsequent to admission and a notice of the determination and appeal procedures will be sent to the applicant as required by Department regulations.

Applicant Information (Must be at least 18 years of age):
Name: • • •
Address: • • •, Mich. 48185
County of Residence: Wayne
Date of Birth: • • •
Phone: • • •
Person to be Admitted (if different from applicant):
Name: • • •
Address: • • •
County of Residence: Wayne

Date of Birth: • • •
Phone: • • •
Signature of Applicant: /s/ • • •
Date: • • •
Relationship to individual: parent
Signature to acknowledge oral explanation of rights set forth in application: Applicant: /s/ • • •
Date: 2-25-75; Individual admitted: (if minor)
/s/ • • • Date: 2-25-75
Signature to acknowledge receipt of copy of application:
Applicant: /s/ • • •, Date: 2-25-75
Individual admitted: (if minor) /s/ • • •
Date: 2-25-75
Person designated by patient to receive copy of application:
Name: Tom Wojciehowski; Address: 7•8 Watersedge;
City: Ann Arbor; State: Mich.; Zip: 48105.
Mailed or given: Feb. 25, 1975.
Action by Hospital: clinically suitable for formal admission
Signed: /s/ Allen K. Thorburn, M.D.; Date: 2-25-75

Your family or guardian and the hospital staff have decided you need to be in a hospital to help solve your problems.

WHEN A PERSON LESS THAN 18 YEARS OF AGE IS PLACED IN A HOSPITAL BY A PARENT OR OTHER GUARDIAN, AN OBJECTION CAN BE MADE. THAT OBJECTION CAN BE EITHER THAT THE PATIENT DOES NOT NEED TO BE IN THE HOSPITAL OR THAT NEEDED TREATMENT WITHOUT BEING IN A HOSPITAL IS AVAILABLE, OR BOTH. THIS OBJECTION IS MADE TO THE PROBATE COURT IN WRITING ON A FORM FROM EITHER THE COURT OR THE HOSPITAL.

IF THE PATIENT IS 13 YEARS OF AGE OR OLDER, HE OR SHE CAN MAKE HIS OR HER OWN OBJECTION. A PERSON THE COURT DETERMINES IS SUITABLE MAY MAKE THIS OBJECTION FOR ANY PERSON LESS THAN 18.

THE OBJECTIONS CAN BE MADE AT THE FOLLOWING TIMES:

1. BEFORE ADMISSION IF ADMISSION HAD BEEN AGREED TO BY THE HOSPITAL BUT DELAYED.
2. DURING THE FIRST 30 DAYS AFTER ADMISSION.
3. AT ANY THREE MONTH PERIOD FROM THE TIME OF THE FIRST OBJECTION OR, IF NO OBJECTION IS MADE EITHER BEFORE ADMISSION OR DURING THE FIRST 30 DAYS, AT ANY THREE MONTH PERIOD FROM THE DATE OF ADMISSION.

WHEN A PATIENT BETWEEN 13 AND 18 TELLS THE HOSPITAL HE OR SHE WANTS TO OBJECT, THE HOSPITAL WILL HELP MAKE THE OBJECTION BY TELLING THE PATIENT WHEN THE OBJECTION CAN BE MADE, PROVIDING THE FORM, HELPING THE PATIENT COMPLETE IT AND SEEING TO IT THAT THE COURT RECEIVES THE OBJECTION. WHEN A PATIENT UNDER 13 INFORMS THE HOSPITAL THAT HE OR SHE WANTS TO OBJECT, THE HOSPITAL WILL NOTIFY THE PROBATE COURT AND REQUEST APPOINTMENT OF A GUARDIAN AD LITEM TO ASSIST THE PATIENT.

A HEARING WILL BE HELD WITHIN 7 DAYS

AFTER THE COURT RECEIVES THE OBJECTION AND THE COURT WILL SEE THAT THE PATIENT'S RIGHTS, SUCH AS A LAWYER, PAID FOR BY THE COURT IF NECESSARY, ARE HONORED.

IF THE COURT AGREES WITH THE OBJECTION, IT WILL ORDER A RELEASE FROM THE HOSPITAL. IF THE COURT DOES NOT AGREE, THE PATIENT WILL STAY AT THE HOSPITAL. THE FACT THAT A PATIENT'S FAMILY OR OTHER GUARDIAN CANNOT OR WILL NOT TAKE CARE OF THE PATIENT WILL NOT STOP THE COURT FROM ORDERING A RELEASE. IF SUCH A SITUATION DOES EXIST, A NEGLECT PROCEEDING WILL TAKE CARE OF THE MATTER. THE OBJECTING PERSON MAY START THIS ACTION IF HE OR SHE WISHES.

In my opinion the person requesting formal voluntary admission of himself/herself is competent to give informed consent to treatment and to execute this agreement.

Signature: M.D.
Date:

The required oral explanation to the individual to be admitted was not given since in my opinion the individual is not in any way capable of comprehending the explanation because .....

Signature: M.D.
Date:

EXHIBIT B

State of Michigan — Department of Mental Health
William G. Milliken, Governor — E. G. Yudashkin, M.D.
Director

An Agency of the Department of Mental Health
YPSILANTI STATE HOSPITAL
3501 Willis Road, Ypsilanti, Michigan 48197
Telephone 313/434-3400
V. A. Stehman, M.D., Superintendent

February 25, 1975

Mr. Tom Wojciehewski
788 Watersedge
Ann Arbor, MI 48105

RE: • • •

Dear Mr. Wojciehewski:

Under the new Mental Health Code, a person being admitted to the hospital under a Formal Voluntary can request that a 3rd copy of his/her Formal Voluntary Admission Application be sent to the person of his/her choice.

Enclosed is your copy of the application per the patient's request. If you have any questions, please don't hesitate to contact me.

Sincerely,
/s/ WILLIAM E. KIRK, M.D.
Director
York Woods Center
WEK:sh
Enc.

EXHIBIT C

AFFIDAVIT

I, Tom Wojciehowski, being first duly sworn, depose and say:

1. I am 24 years old; I live with my wife, Margaret Rowley, at 788 Watersedge Drive, Ann Arbor, Michigan.

2. I am educational supervisor at Family Group Homes for Youth, Inc., 2500 Packard Road, Ann Arbor, Michigan. I have taught there since November, 1973. I currently am in a master's degree program at Eastern Michigan University.

3. I was employed, first as a student teacher, then as a child care worker, at Yorkwood Center for children at Ypsilanti State Hospital, from August, 1972, through November, 1973.

4. At Yorkwood Center, I was group leader for • • •, then 9 years old, from the time he arrived at Yorkwood Center in April, 1973, until I left in November, 1973.

5. At his parents' request, I continued to work with • • • for 5-8 hours weekly, as his "big brother" in a special Yorkwood Center program.

6. I was terminated as • • • "big brother" by Harvey Day of the Yorkwood Center on May 20, 1975, after I wrote a letter to numerous people associated with • • • case at Yorkwood Center on May 6, 1975.

7. • • • has objected to being at Yorkwood Center since November, 1974. On information and belief, no one at the Center informed • • • of his right to object to his confinement at Yorkwood until he was formally voluntarily admitted on the signature of his father on February 25, 1975.

• • •, of course, had been confined for months when he was so admitted.

8. I was the person designated by • • • to receive a copy of that admission. I was not informed on February 25, 1975, that someone could object on • • • behalf to his formal voluntary admission. I did not consider myself an appropriate person to object on • • • behalf when I did learn that someone could object for him, since I was not his parent and he was not in my custody.

9. In my vocational capacity, at Mercywood Hospital, Woodruff Elementary School, and Steppingstone School, as well as Yorkwood and Family Group Homes, since January, 1971, I have worked with and observed several hundred children. I presently am working with 38 adolescents at Family Group Homes, Inc.

10. It is my opinion that • • • is not mentally ill. In my opinion, • • • is neither dangerous to himself or to others.

11. It is my opinion that in the time I have known • • •, he has never been mentally ill or dangerous to himself or to others.

12. There *is not* now and there has never been any *reason* to confine • • • to a locked hospital ward, as he has been so confined since April, 1973.

13. On information and belief, a treatment plan only recently has been requested for • • • from the Yorkwood team working with him.

14. No planning has been made for • • • in writing, except by the particular child care worker, such as myself, assigned to him. This is stated on information and belief.

15. I have no knowledge of what medication currently is being provided to • • •. In the past, he has received medication to enable him to rise during the night to go to the bathroom.

16. Although • • • has emotional problems, I do not believe he should be institutionalized as he has been. I would *recommend* placement with his parent(s), or in foster home care, in a stabilized home-type situation. Further deponent sayeth not.

/s/ TOM WOJCIEHOWSKI

County of Washtenaw
State of Michigan
Sworn to before me
this 29th day of May 1975
/s/ NANCY M. LANGELAND
NOTARY PUBLIC
Acting in Washtenaw County
My Commission Expires May 10, 1978
(Seal)

EXHIBIT D

May 6, 1975

I have long hoped that I would not have to write this letter, but at this time, I feel I must do something. I am extremely concerned about • • • who was commited to Yorkwoods Center on April 19, 1973. My concern centers around the apathetic way in which his case has been handled. On the date above, when • • • was admitted for treatment, there were certain objectives in mind that had to be dealt with. • • • exhibited inappropriate behaviors and had problems that he had to learn to cope with.

Presently, as of this date, • • • is still in residential placement at Yorkwoods Center. That fact is quite clear, but the reason behind it is not. I have worked with • • • since his first day at Yorkwoods Center in the capacity of child care worker, Big Brother, and Advocate. My perception of • • • treatment is as follows:

1) When • • • was admitted to Yorkwoods Center, he exhibited many anxious reactions (whining, rocking back and forth, bedwetting, and withdrawal from adults and peers, amongst other things).

2) • • • parents were also having conflicts which were, many times, projected to their children. These conflicts had to be settled to create a stable home life for • • • upon his return.

3) In October, 1974, clinical rounds were held at Yorkwoods Center concerning the treatment of • • •. At this meeting, all the people who worked with • • •, his therapeutic team, were present. The purpose of the meeting was to assess the progress that • • • had made and to discuss what problems • • • still needed to work on. The findings of this meeting were:

A. • • • had worked successfully on all of his objectives and his inappropriate behavior was reduced to a bare minimum.

B. The consensus of the team was that • • • had two problems left to overcome. Those were 1) his parents were still in conflict, and 2) • • • exhibited "occasional bedwetting."

4) • • • parents have since filed for a divorce, separated, moved back together, gotten separate residences,

and have intermittently seen each other from time to time in • • • presence.

5) • • • has been permitted to see both parents at regular designated times even though his mother has stopped meeting with • • • caseworker.

6) • • • was placed temporarily in a foster home recently with many mixed messages about his family situation still unanswered.

7) • • • has voiced to me many times that he wants to leave Yorkwoods Center but is confused because he cannot accept another placement until he gets a clear message from his parents.

8) Through all of this, • • • behavior has markedly regressed since last November, at which time he felt he had completed his part of the bargain and, yet, had no place to go.

It appears to me that • • • has fulfilled his commitment and received only mixed messages and delay from all concerned. It was shown last fall that • • • could overcome the inappropriate behaviors that were the reason for his voluntary commitment. *It is also quite apparent that* • • • *parents have little investment in him, yet they cannot let go of him.* • • • entered a foster placement with his mother feeling guilty and giving him false hope of rescuing him, and his father agreeing with the placement but not giving up legal custody. Was it actually conceived that • • • would do well in this placement having to deal with those feelings as well as separation anxiety, "new" parents, sibling rivalry, and other feelings encountered in foster placement?

• • •, *being ten years old, cannot look at his situation and objectively present his defense.* Yet emotionally, he is

torn by all of these circumstances and has nothing to grasp unto except for adults that come and go on eight hour shifts and his peers on Unit 2B. This, to me, is not a very conducive environment for growth and seems to be increasingly hindering • • • from ever making a successful transition to the world outside Yorkwoods Center.

As • • • advocate I must ask the following questions:

1) Can the parents of • • • remain the legal guardians of • • • even though they cannot keep him in their household?

2) Can • • • remain incarcerated at Yorkwoods Center after he has successfully completed his treatment goals just because his parents cannot face the guilt of relinquishing custody and because • • • is diagnosed as an "occasional bedwetter"?

3) Is it no wonder why • • • behavior has regressed in the last seven months?

4) If the parents cannot decide what is best for • • •, is there not another alternative besides marking time and having • • • visit them only to return again and again to Yorkwoods Center?

I would hope for an immediate reply from someone. At this point in time, I feel many mixed emotions of sadness, anger, frustration, and confusion. Then I think of • • •, who has felt those emotions ever day for months on end and still manages to find some hope and happiness from time to time. For these reasons, I am asking for an immediate review of the treatment plan for • • •. I want to know exactly what rights, if any, • • • has concerning his present situation. I find it necessary to ask if • • • has a discharge plan! If not,

why not? If there is one, I need to know the objectives stated and when the plan will be *appropriately* implemented.

Sincerely,
/s/ Thomas W. Wojciehowski

TWW:bao
CC: Dr. Davis, MAEDC
Dr. Stehman, Director YSH
Dr. Kirk, Director YWC
Dr. Root, Psychiatrist (Therapist)
Ms. Druker, Psychologist (Family Wkr.)
Mr. Robertson, Unit Staff (Group Leader)
Mr. Pullen, Community Liaison
Ms. Berry, Teacher

2-25-75 Formal Voluntary Admission Application

5-6-75 Letter of Concern

5-12-75 Took • • • out—confronted by H. Day

5-19-75 LOA canceled by H. Day — would not speak to me at that time

5-20-75 Mts./Day, Druker, Root, Hoseinia — terminated, effective immediately

5-24-75 Rec'd letter from Dr. Kirk

EXHIBIT E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

• • •, a minor, by his next friend, Tom Wojciehowski, Individually, and on behalf of all other minors similarly situated, Plaintiffs,	NO. JUDGE AFFIDAVIT OF THOMAS B. DARNTON
vs. THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health, Defendants.	

STATE OF MICHIGAN)
) SS:
COUNTY OF GENESEE)

NOW COMES THOMAS B. DARNTON, and being first duly sworn, deposes and says as follows:

1. He is an attorney duly licensed to practice law in the State of Michigan, and practices primarily in Washtenaw County, Michigan.

2. On May 30, 1975, at the request of Thomas Wojciehowski he went to the York Wood Center, located on the grounds of the Ypsilanti State Hospital, Ypsilanti, Michigan, and spoke with a minor who identified himself as • • •. • • • appeared to be a bright, active boy about 10 years old, with blue eyes and blond hair.

3. During the interview the boy on several occasions expressed his desire to leave the York Wood Center. He also stated that he was willing to have affiant try to help him.

4. Tom Wojciehowski, the adult who requested that affiant see • • •, is an adult who has acted as a "big brother" for the boy for several months.

5. Further, your affiant sayeth not.

Dated: Nov. 18, 1975

/s/ THOMAS B. DARNTON
Attorney at Law
WASHTENAW COUNTY LEGAL AID SOCIETY
130 W. Michigan Avenue
Ypsilanti, Michigan 48197
(313) 481-0500

Subscribed and sworn to before me
this 18 day of November, 1975.
/s/ MARY E. BROWN
NOTARY PUBLIC
Washtenaw County, Michigan
My Commission Expires: Nov. 29, 1978

EXHIBIT F

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

• • •, a minor, by his next friend, Tom Wojciehowski, Individually, and on behalf of all other minors similarly situated,
Plaintiffs,

vs.

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health,
Defendants.

NO.
JUDGE
AFFIDAVIT OF ROSE MARIE ADAMO

STATE OF MICHIGAN)
) SS:
COUNTY OF GENESEE)

NOW COMES ROSE MARIE ADAMO, and being first duly sworn, deposes and says as follows:

1. That she is an attorney with Legal Services of Eastern Michigan, Flint, Michigan.

2. That on September 30, 1975, she went to York Wood Center, located on the grounds of the Ypsilanti State Hospital, Ypsilanti, Michigan, and spoke with • • •, the minor Plaintiff herein.

3. That during the interview, • • • told your affiant that he remembered very well Attorney Darnton's visit in May, 1975, and that he continued to desire to leave York Wood Center and that he wanted your affiant and Attorney Darnton to continue to try to help him.

FURTHER, your affiant sayeth not.

Dated: November 20, 1975

/s/ ROSE MARIE ADAMO
Attorney for Plaintiff
LEGAL SERVICES OF
EASTERN MICHIGAN
412 Genesee Bank Building
Flint, Michigan 48502
(313) 234-2621
(313) 481-0500

Subscribed and sworn to before
me this 20 day of October, 1975.
/s/ JOE A. BENAVIDEZ
Notary Public, Genesee County, Michigan
My Commission Expires: April 10, 1976

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

• • •

TOM WOJCIEHOWSKI, Next Friend
of JOHN DOE, a Minor, on behalf
of JOHN DOE and all others
similarly situated,

Plaintiff,

-vs- Case No. 75-72318

THE DIRECTOR OF THE MICHIGAN
DEPARTMENT OF MENTAL HEALTH,
et al,

Defendants.

ANSWER

Intervenors, Mr. and Mrs. John Doe, Sr., are the parents of John Doe, Jr., the nominal Plaintiff in the above-captioned matter. By their attorneys, MILLER, KLIMIST, COHEN, MARTENS & SUGERMAN, P.C., and in answer to the Complaint filed herein, Intervenors state as follows:

1. Answering Paragraph 1, Intervenors admit that the nominal Plaintiff, John Doe, Jr., is a minor and that the Formal Voluntary Admission provisions of Michigan's Mental Health Code (MCLA 330.1415-1420) took effect approximately November 6, 1974. Intervenors deny that their son, John Doe, Jr., is the "Plaintiff." Intervenors deny that John Doe, Jr., "brings this action," that he "challenges the constitutionality" of the aforementioned statutory provisions, or that he "seeks to have" said statutory provisions "enjoined and declared unconstitutional."

Intervenors do not respond to the remainder of Paragraph 1, which consists of legal theories, arguments and conclusions which are erroneous and for which no answer is required.

Affirmatively, Intervenors assert that, as the natural parents and guardians of John Doe, Jr. they are entitled and duty-bound to provide for his care and custody. This lawsuit was brought by Tom Wojciehowski and his attorneys, Rose Marie Adamo, Thomas Darnton and Gabe Kaimowitz, because they (Mr. Wojciehowski and his attorneys) "seek to have" the aforementioned statutory provisions "enjoined and declared unconstitutional." To achieve that objective, the above individuals, who are callously indifferent to the needs and best interest of John Doe, Jr., merely affixed John Doe, Jr.'s name to the Complaint herein. This was done without the authorization, permission, consent or even knowledge of Intervenors, who first heard of this lawsuit on a radio broadcast.

2. Answering Paragraph 2, that paragraph states a legal theory which is erroneous and for which no answer is required. Affirmatively, Intervenors assert that, to the extent that this suit challenges the confinement of John Doe, Jr. and other individuals, the exclusive remedy is a writ of habeas corpus. Therefore ,this Court lacks jurisdiction over the subject matter of the Complaint because this is not an appropriate cause of action pursuant to 42 USC §1983, and the nominal Plaintiff has failed to exhaust his available state remedies or otherwise satisfy the jurisdictional requirements of 28 USC §2254.

The "real" Plaintiffs herein are Mr. Wojciehowski, Ms. Adamo, and Messrs. Darnton and Kaimowitz. None of the aforenamed individuals possesses either the authorization or standing necessary to bring this lawsuit.

3. Answering Paragraph 3, Intervenors deny the allegations of jurisdiction contained therein for the reasons set forth in their answer to Paragraph 2.

4. Answering Paragraph 4, Intervenors deny that this is a proper cause for determination by a three-judge court pursuant to 28 USC §§ 2281 and 2284 for the reasons set forth in their answer to Paragraphs 2 and 3. The remainder of that paragraph consists of legal theories and conclusions which are erroneous and for which no answer is required, and of the stated intentions of Mr. Wojciehowski and his attorneys, which are not attributable to John Doe, Jr. or the members of the putative class, and for which no answer is required.

5. Answering Paragraph 5, Intervenors admit that their son, John Doe, Jr., is eleven years old and a citizen of the United States. Intervenors deny that their son is or ever has been "incarcerated" which allegation should be striken as false and misleading. Affirmatively, Intervenors assert that their son was admitted to the York Woods Center for Children to receive the medical care and treatment necessitated by his illness. John Doe, Jr., suffers severe mental and emotional illness. From approximately age four and thereafter, John Doe, Jr., has exhibited the following:

— Encephalopathy (brain damage);
— Many of the features of an autistic child;
— Borderline retarded intellectual potential and functioning;
— Possible arrested hydrocephaly;
— Psychotic-like behavior;
— A borderline psychotic personality disorder;
— Deep, seething rage;
— An inability to distinguish fantasy from reality;

— Latent schizophrenia and possible childhood schizophrenia;
— An obsessive preoccupation with death, blood and gore;
— Bizarre and widely fluctuating relationships with people in his life;
— Compulsive, violent, assaultive behavior;
— Severe anxiety and withdrawal;
— Echolalia with bizarre and totally inappropriate verbal responses;
— Enuresis and encopresis

Intervenors love their son. As parents and natural guardians of John Doe, Jr., Intervenors have a moral and legal obligation, as well as a legal right, to provide for his care and custody. That obligation includes a duty to provide for their son's medical needs, including treatment and care for his mental and emotional illness. In furtherance and fulfillment of that parental responsibility, Intervenors admitted their son to York Woods in order to secure medical treatment and care for his severe mental and emotional illness.

6. Answering Paragraph 6, Intervenors admit that Mr. Wojciehowski worked at York Woods Center, that Mr. Wojciehowski became acquainted with John Doe, Jr., while at York Woods, and that Mr. Wojciehowski continued as a "Big Brother" to John Doe, Jr. from approximately December of 1973 until May of 1975. Intervenors deny that Mr. Wojciehowski is suitable or competent to be John Doe, Jr.'s Next Friend. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations in Paragraph 6, and leave Mr. Wojciehowski and his attorneys to their proofs.

Affirmatively, Intervenors assert that they are not in-

competent, unsuitable or neglectful parents and that they are neither assumed nor actual adversaries of their son. Intervenors oppose the initiation and continuation of this suit and oppose the appointment of any Next Friend, and particularly Mr. Wojciehowski, for the purposes of maintaining this suit. Further, Intervenors allege that this Court lacks authority to appoint a Next Friend for the purpose of maintaining this lawsuit absent a prior showing that Intervenors are unsuitable parents and actual adversaries of their son.

7. Answering Paragraph 7, Intervenors admit that the Director of the Michigan Department of Mental Health is a Defendant herein and that said position is currently occupied by Donald C. Smith. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations contained therein, and leave Mr. Wojciehowski and his attorneys to their proofs.

8. Answering Paragraph 8, Intervenors admit that the Director of Ypsilanti State Hospital is a Defendant herein and that said position is currently occupied by Vernon Stahman. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations in Paragraph 8, and leave Mr. Wojciehowski and his attorneys to their proofs.

9. Answering Paragraph 9, Intervenors admit that the Director of York Woods is a Defendant herein and that said position is currently occupied by William Kirk. Intervenors are without knowledge or information sufficient to form a belief as to the truth of falsity of the remaining allegations in Paragraph 9, and leave Mr. Wojciehowski and his attorneys to their proofs.

10. Answering Paragraph 10, Intervenors admit that Harvey Day works at York Woods. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations contained therein, and leave Mr. Wojciehowski and his attorneys to their proofs.

11. Answering Paragraph 11, Intervenors deny that John Doe, Jr., brings this action on behalf of himself or any other persons. This action is brought by Mr. Wojciehowski and his lawyers who are callously indifferent to the best interests of John Doe, Jr. and the other members of the putative class. Further, Mr. Wojciehowski and his attorneys filed the Complaint herein one month after the Honorable James Harvey of the United States District for the Eastern District of Michigan ruled that they should not involve "their client," John Doe, Jr., in a complex, federal class action because that would be harmful to John Doe, Jr.'s best interests. See Opinion denying Petition to Intervene, *Deborah White* v *The Director of the Michigan Department of Mental Health, et al*, Case No. 75-10022.

12. Answering Paragraph 12, Intervenors deny the allegations contained therein.

13. Answering Paragraph 13, Intervenors deny the allegations contained therein.

14. Answering Paragraph 14, Intervenors deny the allegations contained therein.

15. Answering Paragraph 15, Intervenors deny the allegations contained therein.

16. Answering Paragraph 16, Intervenors deny the allegations contained therein. John Doe, Jr. is a purely nominal Plaintiff who has been virtually abducted by the

real Plaintiffs, Mr. Wojciehowski and his attorneys, who are callously indifferent to the needs and interests of John Doe, Jr. and the putative class.

Mr. Wojciehowski's attorneys have already represented to this Court that from their point of view (i.e. the point of view of Mr. Wojciehowski and his attorneys) whether the nominal Plaintiff needs in-patient medical care, whether the nominal Plaintiff would be traumatized by an adversary, pre-admission judicial hearing, or whether the prospect of such traumatization would serve to effectively deny the nominal Plaintiff necessary medical care, are matters of total irrelevance.

Further, the claims asserted in the Complaint are directly contrary to the best interests of the nominal Plaintiff and the putative class. If accepted, said claims would subject mentally ill children and their families to stigmatizing public records and judicial findings of insanity, and to traumatic, adversary judicial proceedings which would compound their mental and emotional problems. Additionally, said claims would deny needed medical treatment to mentally ill children. Finally, said claims would undermine the principle of parental responsibility and accountability which is fundamental to the protection of all children, including children who suffer mental or physical illness, in a democracy such as ours. "Many children [would] see the [nominal] Plaintiff's victory, not as a blessing, but as a curse. One can readily imagine some children saying to the [nominal] Plaintiff, 'if you want to help us, drop your lawsuit.'" See Opinion of Honorable Victor J. Baum in *Clarice Jobes, et al* v *The Michigan Department of Mental Health, et al*, Wayne County Circuit Court, Civil Case No. 74-004-130-DC.

17. Answering Paragraph 17, Intervenors deny the allegations contained therein.

18. Answering Paragraph 18, Intervenors deny the allegations contained therein.

19. Answering Paragraph 19, Intervenors admit the allegation contained therein. Further, Intervenors assert that they admitted their son to in-patient care at York Woods Center because he is severely mentally and emotionally ill as described in the Answer to Paragraph 5. Intervenors reach this decision after consultation with, and in accordance with the advice of, a great many psychiatrists, physicians, psychologists, and other professional personnel trained in the diagnosis and treatment of mental illness.

20. Answering Paragraph 20, Intervenors admit that no court hearing was held prior to John Doe, Jr.'s voluntary admission to York Woods Center. Further, Intervenors assert that an adversary, pre-admission judicial proceedings would have compounded their son's mental and emotional illness, and would have subjected their son and his family to permanent and irreparable stigmatization and traumatization.

21. Answering Paragraph 21, Intervenors deny the allegations contained therein. Further, Intervenors assert that on February 25, 1975 and subsequently, John Doe, Jr. was advised of his right to object to his hospitalization at York Woods Center and did not object.

22. Answering Paragraph 22, Intervenors admit that on or about February 25, 1975 Mr. Wojciehowski received a copy of Exhibits A and B.

23. Answering Paragraph 23, Intervenors deny the alle-

gations contained therein. Mr. Wojciehowski received a copy of John Doe, Jr.'s formal voluntary admission application. That document sets forth in bold type all the necessary information as to who may object and how. As the individual designated to receive said document, Mr. Wojciehowski had a prima facie right to object to the nominal Plaintiff's admission. Further, the cover letter accompanying said application expressly advised Mr. Wojciehowski to direct any questions he had to the Director of York Woods. On information and belief, Mr. Wojciehowski did not ask the Director of York Woods if he could object. Further, since approximately June of 1975 (six months prior to this lawsuit) Mr. Wojciehowski has had the assistance and advice of his attorneys in this lawsuit. Finally, in September of 1975 the Honorable James Harvey specifically advised Mr. Wojciehowski and his attorneys that an objection to the admission of the nominal Plaintiff to York Woods could be filed in probate court.

24. Answering Paragraph 24, on information and belief Intervenors admit that Mr. Wojciehowski wrote the letter referred to as Exhibit "D." Intervenors deny the remaining allegations contained therein.

Affirmatively, Intervenors assert that Mr. Wojciehowski is not qualified to make any diagnosis as to the mental and emotional illness of the nominal Plaintiff. John Doe, Jr. is severely mentally and emotionally ill and very dangerous to himself and others for the reasons set forth in the answer to Paragraph 5. In December of 1975, the nominal Plaintiff swallowed a great number of pills which he had obtained surreptitiously and was spared serious harm only because the pills were harmless. In February of 1975, an attempt was made to temporarily place the nominal Plaintiff with a foster family. The prospective foster parents re-

turned the nominal Plaintiff to York Woods within twenty-four hours because he had injured their two year old infant by physically assaulting the infant and attempting to set the infant on fire.

25. Answering Paragraph 25, Intervenors admit that Mr. Wojciehowski was terminated as a big brother on about May 20, 1975. Affirmatively, Intervenors assert that Mr. Wojciehowski was terminated because he disclosed totally false, malicious, stigmatizing and confidential information concerning John Doe, Jr. and his family to persons outside the Department of Mental Health and in violation of MCLA 330.1746. Further, Mr. Wojciehowski initiated this suit for the purpose of retaliating against York Woods for his termination.

26-29. Answering Paragraphs 26 through 29, Intervenors admit that the nominal Plaintiff was visited by attorneys Darnton and Adamo. Intervenors deny the remaining allegations contained therein.

Affirmatively, on information and belief, Intervenors assert that during said visits, Mr. Darnton and Ms. Adamo exercised undue influence on John Doe, Jr. in an attempt to persuade him to serve as their Plaintiff; that they misled, harassed and badgered him; that they told him to stop attending bi-weekly therapy sessions with a psychiatrist; and that, despite all the foregoing, John Doe, Jr. never expressed a clear desire to leave York Woods and never expressed any desire to start this suit. John Doe, Jr. reacted to the foregoing "visits" by exhibiting an increase and an intensification of many of the indicia of his mental illness, such as seething rage, bizarre, violent and destructive behavior, echolalia, and severe anxiety and withdrawal.

30. Answering Paragraph 30, Intervenors admit that

John Doe, Jr. remains as an in-patient at York Woods and that he has not received a hearing before any Michigan court or tribunal. Intervenors deny that John Doe, Jr. has objected to his hospitalization. Intervenors deny that John Doe, Jr. has ever been "incarcerated." Intervenors continue to spend a great deal of time with their son during his hospitalization. They visit with their son at York Woods on a regular and frequent basis. John Doe, Jr. leaves York Woods to spend time with his parents on a regular and frequent basis of at least one day each week and often more. Further, it is Intervenors' hope and expectation that their son's mental illness will be sufficiently alleviated by the Summer or Fall of 1976 so that his in-patient hospitalization can be concluded.

Further, Intervenors assert that the nominal Plaintiff has not received a hearing before a Michigan court because Mr. Wojciehowski has refused to utilize any of the expeditious remedies available in Michigan courts despite Judge Harvey's Opinion that they should do so to serve "their client's" best interests.

31. Answering Paragraph 31, Intervenors deny the allegations contained therein.

32. Answering Paragraph 32, Intervenors deny the allegations contained therein. In support of their denial, Intervenors assert that the nominal Plaintiff and the putative class have a choice of expeditious and adequate remedies in Michigan courts, including an objection filed pursuant to MCLA 330.1415-1420; a writ of habeas corpus; or neglect proceedings in probate court.

Further, John Doe, Jr. and the members of the putative class are suffering no harm whatsoever as the result of the operation of the Michigan Mental Health Code because

said statutory provisions enable them to obtain treatment for their medical problems without the stigmatization and traumatization of public records and adversary judicial proceedings. To the contrary, it is the conduct of Mr. Wojciehowski and his attorneys and the initiation and continuation of this lawsuit which has and continues to cause John Doe, Jr. irreparable harm.

Hospitalization and treatment at York Woods significantly alleviated John Doe, Jr.'s mental and emotional problems. By the initiation of this unauthorized lawsuit, Mr. Wojciehowski and his attorneys have subjected the entire Doe family to the stress of adversary litigation (where no adversary relationship exists) and permanent public stigmatization. Moreover, as a result of this lawsuit and the aforementioned visits by Mr. Wojciehowski's attorneys, progress in the treatment of John Doe, Jr.'s mental problems has stopped and, in fact, John Doe, Jr. has regressed.

The irreparable harm and injury which Mr. Wojciehowski and his attorneys have done to "their client," John Doe, Jr., by this lawsuit, is the very "relief" which they insist upon for every member of the putative class in the form of a mandatory, public, adversary judicial proceeding prior to hospitalization for treatment of mental disease. It is the "relief" which Mr. Wojciehowski and his attorneys seek which would cause irreparable harm to John Doe, Jr. and the members of the putative class. Such harm, however, is admittedly irrelevant to Mr. Wojciehowski and his attorneys.

33. Answering Paragraph 33, Intervenors reallege their answers to Paragraph 1 through 32 as set forth above.

34. Answering Paragraph 34, Intervenors deny the al-

legations contained therein. John Doe, Jr. has never been incarcerated. Joe Doe, Jr. has not been "subjected to forced chemotherapy." On the advice and judgment of his parents and physicians, he has received medication to relieve physical illnesses and enuresis. John Doe, Jr. was never "stigmatized" by hospital records until this lawsuit. He has now, however, been so stigmatized due to the release of confidential and misleading information by Mr. Wojciehowski and his attorneys. John Doe, Jr. has never been transferred between hospitals.

35. Answering Paragraph 35 and subparagraphs (a) and (b) thereof, Intervenors admit that John Doe, Jr. did not receive an adversary and traumatic judicial hearing prior to his hospitalization for treatment of mental illness. Intervenors deny that such a hearing is constitutionally mandated or in the best interest of John Doe, Jr. and the putative class. Intervenors deny each and every other allegation contained in Paragraph 35 and subparagraphs (a) and (b) thereof.

36. Answering Paragraph 36, Intervenors deny the allegations contained therein.

37. Answering Paragraph 37 and subparagraphs (a), (b), (c), (d) and (e) thereof, Intervenors deny the allegations contained therein.

WHEREFORE, Intervenors pray that the Complaint be dismissed in its entirety and that Intervenors be granted such actual costs and attorneys fees as the Court may deem appropriate.

AFFIRMATIVE DEFENSES

NOW COME INTERVENORS, by their attorneys, MILLER, KLIMIST, COHEN, MARTENS & SUGERMAN, P.C., and for their Affirmative Defenses state as follows:

1. This is not a true class action.

2. This action is unauthorized.

3. John Doe, Jr. is a purely nominal and improper Plaintiff. Mr. Wojciehowski and his attorneys are the real Plaintiffs herein, and they lack standing to bring this action.

4. The Court lacks jurisdiction over the subject matter of this action.

This action, at bottom, is intended and has the effect of divesting Intervenors of their obligation and right to the custody and control of their child, John Doe, Jr. To entertain this action, absent a prior showing of parental unsuitability or neglect, is an unconstitutional infringement without due process of law on John Doe, Jr.'s right to the nurturing care and custody of his parents, and the right and duty of his parents to provide such care and custody. Further, matters of parental unsuitability and neglect lie within the primary and exclusive competence of state courts.

5. The Court lacks jurisdiction over the subject matter of this action because a writ of habeas corpus is the exclusive remedy for challenging the confinement of individuals in a mental institution.

6. Plaintiffs have failed to exhaust available state remedies.

7. Parents and guardians are responsible for the welfare of their children. They are the persons held accountable, both civilly and criminally, to see to the physical, medical and emotional needs of their children. The responsibilities imposed upon parents and guardians include the corollary duty to secure appropriate medical treatment, whether physical or mental, as required by the facts or circumstances. Any rule of law that divests children of the protection and accountability of parents and guardians leaves children without the safeguards and protections their dependent status requires. Such a rule of law would be subversive of the family as a unit and hence of the social order which is the legally recognized basis of all family law.

8. Adults are conceded the right by the Plaintiffs to voluntary medical treatment for emotional problems without the necessity of being stigmatized as insane through an involuntary proceeding. Plaintiffs' insistence that children, in order to secure medical treatment for emotional ills must first be declared insane, sets up an arbitrary and unreasonable classification discriminating against the just rights of children and their parents and guardians in violation of the Federal and Michigan Constitutions.

9. Public health facilities are designed primarily to serve the needs of persons whose financial conditions prevent the use of private facilities. Children with emotional ills may secure, through their parents and guardians, private help without prior adjudications of insanity. Plaintiff's adjudication of insanity sets up an arbitrary and unreasonable classification discriminating against those whose financial status requires them to use public facilities in violation of the Federal and Michigan Constitutions.

WHEREFORE, Intervenors pray that the Complaint be dismissed in its entirety and that Intervenors be granted such actual costs and attorneys fees as the Court may deem appropriate.

MILLER, KLIMIST, COHEN, MARTENS
& SUGERMAN, P.C.

By.....
BRUCE A. MILLER

-and-

By.....
SAMUEL C. McKNIGHT
Attorneys for Intervenors
2460 First National Building
Detroit, Michigan 48226
965-7540

DATED: APRIL 22, 1976.

STATE OF MICHIGAN)
) SS:
COUNTY OF WAYNE)

I, Ralph D. Rabinovitch, M.D., after first being duly sworn, upon my oath affirm and say that:

I am a graduate in medicine, McGill University, Montreal, Canada. I received my psychiatric training at Toronto University and New York University. I served as a Research Fellow in Child Psychiatry at Bellevue Hospital. From 1949 to 1956, I was Chief of Children's Psychiatric Service, and Associate Professor of Psychiatry at the University of Michigan. In 1956, I assumed the position of Director of Hawthorn Center, an inpatient, outpatient and day care facility for treatment, training and research in

child psychiatry under the Department of Mental Health, State of Michigan. Hawthorn Center is now one of the largest state-sponsored mental health centers for children and adolescents in the country. Since 1971, I have been Director of Clinical Research at Hawthorn Center.

Over a period of many years, I have served as consultant to numerous social agencies and schools. One of my major concerns is the integration of child psychiatry, social work and education on a broad community level. I have written on a wide range of topics relating to the psychopathology of childhood and psychotherapy, including childhood schizophrenia, juvenile delinquency, residential treatment, reading and language disabilities and, most recently, drug abuse and its psychological and social implications.

Attached to this Affidavit are case summaries, prepared under my direction and supervision, describing the inpatient population at Hawthorn Center on May 1, 1974. These studies are, to the best of my knowledge, true and accurate except to the extent necessary to preserve anonymity and confidentiality. Also, these case summaries are representative of the present inpatient population at Hawthorn Center.

The issues involved in psychiatric inpatient care for children are complex. As so often happens in abstract discussions of complex social issues, much current rhetoric concerning psychiatric hospital care for children has a great tendency to stray from fact. Oversimplification and overgeneralization cloud the basic issues.

No one likes the idea of psychiatric hospitalization for children. The concept tends to evoke fears and anxieties in many concerned citizens, and, because children are involved, these emotions are particularly exploitable.

Often two distinct and separate issues are confused — the right to treatment and the quality of treatment. The community, through its governmental enabling and licensing agencies, and through its courts, has the right and duty to demand the highest standards of care for its disturbed children.

The solution to substandard treatment is not the abolition of all treatment opportunities but the amelioration or replacement of substandard programs. The routine, subtle use of such opprobrious invectives as "incarceration', 'guinea pig experimentation', 'drugging' in references to all children's psychiatric hospitals is as inflamatory as it is unreasonable. There are good children's psychiatric hospitals and bad children's psychiatric hospitals; throughout this Affidavit, I am referring to the good ones.

In the practice of child psychiatry no situation requires more care and sensitivity than the planning of hospitalization for a child. Two broad issues are involved — clinical considerations and the reactions of child and family.

1. *Clinical Considerations.*

Currently the assumption is often expressed that admission procedures are cursory, that parents can simply deposit children and leave. Nothing could be farther from the truth. The usual minimal admission procedure is as follows: first, admission is recommended by a worker in the community who knows the child and family well — the pediatrician, family physician, community mental health clinic worker, school social worker or psychologist, judge or court worker. Next, the child is evaluated in the hospital outpatient clinic with the most experienced professional staff involved. Then full consideration is given the possibilities for non-hospital treatment alternatives.

For the large majority of children for whom hospitalization is recommended, numerous treatment alternatives have already been tried in the community. The case summaries of the inpatients at Hawthorn Center demonstrate that nearly every parent has tried some form of alternative treatment before agreeing to hospitalization.

These case summaries also illustrate the wide range of disturbances the patients suffer. Each child requires detailed study, no less than is appropriate in any medical clinic. Too often it is forgotten that child psychiatry is a branch of pediatrics, and not an isolated or independent discipline. Childhood schizophrenia, brain injury, epilepsy, anorexia and phobic states are no less medical than chronic arthritis, brain tumor, cardiac disease, endocrine imbalance or asthma.

Despite years of public education, it is still often difficult to convince parents and children of these realities and of the fact that there should be no special stigma attached to mental illness or emotional disturbance.

2. *Reactions of Child and Family.*

Any hospitalization of a child is rarely easy for child or parents; psychiatric hospitalization is particularly difficult. Acceptance of the recommendation for admission often leads to strong resistance. In many cases it is more difficult for the parents than for the child. There are many reasons for this. The parents' compassion for the child and his plight may be overwhelming. The concept of hospitalization may suggest dire portent. Strong feelings of inadequacy or guilt may be activated. Despite the fact that the need for hospitalization is clearly appreciated, the parent may find it impossible to follow through, leading to postponements that further jeopardize the child's future.

The following two case studies are typical:

GEORGE

George, an 11-year-old boy, was referred to Hawthorn Center for admission by a school social worker because of long-term inability to attend school dating back to his early school days. In addition to the school refusal problem George had developed phobic symptoms, being unable to leave home even for brief shopping trips. George simply sat at home day and night. He also had discontinued all contact with peers. The school's special services had worked very hard to help George and he had received eighteen months of psychotherapy in the community. Both the school and the referring community clinic had strongly recommended inpatient treatment but the parents had been unable to accept the recommendation.

Again inpatient treatment was recommended by the hospital staff and again the parents refused. Another three-month trial of outpatient treatment proved fruitless and George remained immobilized at home. After a further delay the parents asked if they might talk with the parents of other children who had been admitted to the hospital with similar problems. The group was helpful and finally George was admitted, his parents still extremely threatened and anxious.

In the hospital George responded rapidly to the milieu, the school program and psychotherapy. He was able to return home and to the public school in three months and has continued to do well.

JOYCE

At age 7 years Joyce was referred to the psychiatric hospital because she had never talked in school. The parents

reported that she had never uttered a word to anyone outside the immediate family. The diagnosis of elective mutism was made and outpatient treatment was begun. Joyce did not respond and a brief period of inpatient care was felt necessary to help reverse the pattern of mutism. Joyce was willing to enter the inpatient program but the parents' anxiety did not permit them to follow through. They were encouraged to keep in touch with the hospital and the door was left open for Joyce's admission at any time.

The hospital did not hear from the family for the next four years, when Joyce was re-referred. She had remained mute throughout this entire period and her social adjustment had deteriorated seriously. She was withdrawn and depressed. Again inpatient treatment was strongly recommended and rejected by the parents. They simply could not bring themselves to the point of separation and feared for Joyce's safety in the hospital. Again the door was left open and nine months later the parents called to ask if Joyce could be admitted. She remained in hospital for five months and made slow, steady improvement. She talked first to her therapist, then to her classroom teacher, to a nurse, to several child care workers, and finally to other students. Her anxiety and depression lifted and she returned to home and public school where she is adjusting well, talking comfortably and enjoying life.

Casebooks are filled with examples of the anxiety that the need for a child's psychiatric hospitalization engenders in parents, to the point that many parents cannot bring themselves to acquiescence even when they know that hospitalization is imperative. If confronted with the prospect of a coerced adversary court hearing, many parents would

simply be unable to undergo the trauma. George and Joyce are but two common examples.

In the above two cases hospitalization was finally made possible and the outcome was positive. Unfortunately, not all cases end this way. In many, hospitalization continues to be resisted with progressive deterioration in the child's adjustment and in some cases, ultimate disaster.

DOLORES

At age 14 Dolores was referred by the school and the family service agency for consideration of admission to hospital because of her aggressive, threatening behavior at home and her extreme unhappiness and expressed anger at school. Dolores was particularly negative towards her sister, Tina, two years younger, whom she viewed as the favored child in the family.

Diagnostic studies in the hospital outpatient clinic indicated that Dolores was tormented by feelings of self-deprecation and jealousy and she was having great difficulty controlling her aggressive impulses.

Hospitalization was recommended and every effort was made to persuade the parents to agree, but they felt much threatened by the prospect of separation and Dolores remained at home. At the time of the outpatient evaluation there was no clear-cut indication for involuntary commitment.

Ten months later Dolores murdered Tina in an episode of rage, brought on by a new dress than Tina was wearing.

BILL

From age 13 years, Bill had been involved in drug abuse, using many street drugs, often in large quantity. At age 16,

after a serious overdose, he was referred by the family doctor for hospitalization.

Diagnostic studies in the hospital outpatient clinic revealed a very bright, sensitive, troubled boy who had established a self-image, life style and subgroup peer identification from which he could not escape. Immediate hospitalization was indicated and strongly recommended.

Bill was more than willing to accept inpatient care, but he was persuaded by a community drug abuse clinic and an agency lawyer to reject the recommendation. His parents could not prevail and Bill remained on the streets.

Four months later Bill died in a dope house from an overdose. Several times in the previous months, desperate for help, Bill had called the doctor with whom he had talked at the hospital but the drug abuse clinic and the lawyer continued to dissuade him from accepting "incarceration".

These tragedies are difficult enough for families to bear without the added burden of undue blame or assumed inevitable negative parent motivation. The assumption that most parents are the enemies of their troubled children is pure myth. Clinical reality, in fact, tells us clearly that in most families, when the necessity for child's psychiatric hospitalization becomes clear, there are appropriate mutual human responses of compassion. The large majority of parents and children remain humane, decent people who respond appropriately at time of family crisis.

Coerced adversary hearings will have a particularly negative effect upon children of poverty families. Professional literature documents the fact that low income families have traditionally been reluctant to use mental health services. The real battle in this area has been to design

practical services that meet needs, and to motivate families to use the services that are available. Coerced adversary court hearings will simply prove an insurmountable barrier. It is often difficult for low income families to discuss domestic problems in the clinic setting. It will be all the more so in the court setting. It is unrealistic to expect any parent to willingly testify to personal family problems for a public record in a court of law.

In the context of coerced adversary proceedings, psychiatric disturbance in children becomes no longer a medical concern but a legal one. Responsibility for the health of children with a wide range of medical-psychiatric problems will be removed from medical and placed under legal responsibility. What criteria will the Court use? If the only method of hospitalization for a child is that presently used for involuntary commitment (homicide or suicide threat), over 90% of patients will be denied the hospital care they need. The attached case summaries demonstrate this point (see cases 5, 12, 25, 26, 37, 48, 59, 85, 91, 97, 139).

If the need for hospitalization itself is used, a very serious problem is presented. The Court will have to develop criteria to determine that need. How much anxiety will the Court require before ordering hospitalization? What weight loss will the Court require before adolescents with anorexia nervosa are permitted to receive hospital care? How severe must a child's rage reaction be before the Court will order his hospitalization for psychomotor epilepsy? How discouraged, immobilized and negative about himself must a non-suicidal, depressed child be before the Court will sanction his admission to hospital for treatment?

These are not irrelevant or rhetorical questions. They strike at the heart of the issue before us and cannot be ignored. In my opinion, to redefine emotional disturbance

in children to conform to a judicial rather than a medical standard is regressive, anachronistic and dangerous.

/s/ RALPH D. RABINOVITCH, M.D.

Subscribed and sworn to before me on this 7th day of June, 1976.

/s/ CELIA T. BUCHINSKI
Notary Public, Wayne County, MI
My commission expires: October 8, 1978

No. 1

Presenting Problem: Bizarre behavior including unprovoked screaming spells, panic attacks and aggressive acting out; very limited and idiosyncratic speech and language; severe asocial withdrawal.

Diagnosis: Childhood Schizophrenia.

Previous Interventions: School special services. Psychotherapy — out-patient clinic, community hospital. In-patient care — public psychiatric hospital.

No. 2

Presenting Problem: Bizarre behavior, two-months duration; auditory hallucinations and delusions; delinquent acting-out in the community including breaking and entering; preoccupation with knives and frequent "play with knives".

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: Psychiatric study hospital outpatient clinic. Juvenile Court. Juvenile detention facility. Private psychiatric hospital — in-patient care. Committed as mentally ill to Hawthorn Center through Probate Court.

No. 3

Presenting Problem: School refusal — refractory to community efforts; severe academic learning impairments.

Diagnosis: Dyslexia, severe. Psychoneurosis. Neglected child.

Previous Interventions: School special services.

No. 4

Presenting Problem: Toxic states from drug and alcohol overdoses in community; chronic stealing and other acting-out behavior; fire-setting.

Diagnosis: Psychoneurosis

Previous Interventions: Psychotherapy in out-patient clinic, community hospital. In-patient hospital care following emergency admission for drug overdose — community hospital. In-patient care — private psychiatric hospital in community.

No. 5

Presenting Problem: Bizarre behavior pattern since infancy; failure to develop speech and language for communication; accident-proneness despite excellent home care; panic attacks with minimal provocation.

Diagnosis: Childhood Schizophrenia.

Previous Interventions: Speech and hearing studies — community clinic. Family therapy — community mental health clinic. Psychiatric consultation — specialized clinic. Psychiatric day care in community mental health program.

No. 6

Presenting Problem: Bizarre behavior with many delusions, inappropriate affect and apparent disorientation—acute onset.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: In-patient care—public psychiatric hospital for acute psychosis with transfer to H.C.

No. 7

Presenting Problem: Sadistic aggression against younger children and animals; fire setting including gas tank of family car; inability to attend public school.

Diagnosis: Borderline mental retardation. Chronic deprivation and neglect.

Previous Interventions: School special services. Special education classroom in public school. Diagnostic studies—psychiatric hospital in community. Hospitalization—psychiatric hospital in community. Placements—two residential group care programs—excluded from both because of behavior. Committed as mentally ill to Hawthorn Center through Probate Court.

No. 8

Presenting Problem: Impulsive acting-out behavior; excluded from school because of threats with knives; very unhappy child with negative self image.

Diagnosis: Relatively affectionless personality.

Previous Interventions: School special services. Family therapy — private practitioners. Special education classroom in public school. Juvenile court and detention facility. Hospitalizations—private and public hospitals.

No. 9

Presenting Problem: Marked sexual preoccupations and sexual acting-out in community; unresponsive to efforts of protective services in community.

Diagnosis: Psychoneurosis. Chronic deprivation and neglect.

Previous Interventions: School special services. Special education classroom in public school. Protective services—many community agencies.

No. 10

Presenting Problem: Fire setting; grave danger to life of family members and neighbors; life-long pattern of developmental and adjustment problems.

Diagnosis: Schizophrenia.

Previous Interventions: Pediatric efforts from earliest years. School special services. Family therapy—out-patient clinic community hospital.

No. 11

Presenting Problem: Uncontrolled impulsive behavior at school and in community; primitive behavior such as persistent urinating on other children.

Diagnosis: Encephalopathy; deprivation and neglect.

Previous Interventions: In-patient care program for retarded children. Hospitalization—long-term treatment in psychiatric hospital. Placement — residential group care program—excluded because of behavior. Phychiatric day care in mental health program.

Diagnosis: Schizophrenia.

No. 12

Presenting Problem: Increasing social withdrawal and inertia; bizarre preoccupations; alternating excitement and depression, requiring emergency admission.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: School special services.

No. 13

Presenting Problem: Suicide attempts requiring hospitalization in community; sadistic physical attacks on children and adults.

Diagnosis: Schizophrenia.

Previous Interventions: School special services. Family

therapy. Several community mental health clinics. Placement in two residential group care programs—excluded from both because of behavior. Juvenile court and detention facility. Hospitalization—private psychiatric hospital in community.

No. 14

Presenting Problem: Very poor adjustment at home, at school and in community; repeated stealing and vandalism in community; strong feelings of rejection with reactive counter-aggression.

Diagnosis: Psychoneurosis; chronic deprivation and neglect.

Previous Interventions: Family therapy. Community health clinic. Special education class in public school. Placement in residential group care program in community—excluded because of behavior.

No. 15

Presenting Problem: Marked unhappiness with feelings of isolation; negative self percept and inability to relate with peers; reactive behavior problems.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services.

No. 16

Presenting Problem: Encopresis—intractible.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services—three school systems. Placement in residential group care program in community—excluded because of problem.

No. 17

Presenting Problem: Sadistic sexual attacks on younger

children; severely destructive temper outbursts; unable to attend school.

Diagnosis: Encephalopathy with impulse disorder.

Previous Interventions: School special services. Day care psychiatric program in the community—excluded because of behavior. Juvenile court interventions. Hospitalization—private psychiatric hospital in community.

No. 18

Presenting Problem: Very poor social skills and negative self percept; marked academic underachievement, reactive; chronic behavior problem at home, in school and in community.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services.

No. 19

Presenting Problem: Repeated sexual assaults on children in the community.

Diagnosis: Relatively affectionless personality. Dyslexia.

Previous Interventions: Psychotherapy — out-patient clinic. Special education classroom—public school. Day care program, psychiatric. Placement—private boarding school—excluded because of behavior.

No. 20

Presenting Problem: Severely disabling phobias; fire-setting; profound depression; severe reading problems at school with reactive anxiety.

Diagnosis: Psychoneurosis. Dyslexia.

Previous Interventions: Family therapy — community mental health resource. Family therapy—family service agency.

No. 21

Presenting Problem: Elective mutism; school refusal; severe temper outbursts; destructive and threatening behavior.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services. Psychiatric evaluation—child guidance clinic. Phychotherapy—out-patient clinic.

No. 22

Presenting Problem: Markedly aggressive behavior at home and in community; attempted to drown younger brother; fire-setting.

Diagnosis: Relatively affectionless personality.

Previous Interventions: School special services. Family therapy in community mental health clinic.

No. 23

Presenting Problem: Suicide attempt with severe threat to life.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: Psychotherapy — community mental health resource.

No. 24

Presenting Problem: Fire-setting in community; excluded from school because of chronic unmanageable behavior.

Diagnosis: Encephalopathy with impulse disorder.

Previous Interventions: Psychiatric evaluations—in public school and several community clinics. Referred for placement in several group care programs in community but not accepted.

No. 25

Presenting Problem: Marked sexual discomfort with fetishism, transvestism and reactive anxiety; enuresis, intractable.

Diagnosis: Psychoneurosis with obsessive-compulsive and depressive symptoms.

Previous Interventions: School special services. Family therapy in community family service agency.

No. 26

Presenting Problem: Encopresis—intractable; impulsive temper outbursts; very poor peer relationships; unhappy and discouraged.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: Nursery school. School special services. Family therapy—family service agency. Phychotherapy—out-patient clinic.

No. 27

Presenting Problem: Sadistic behavior toward younger sibling and animals—potentially dangerous; fire-setting at home and in neighborhood; previously hospitalized elsewhere because of child abuse—patient the victim.

Diagnosis: Psychoneurosis reactive to abuse.

Previous Interventions: Pediatric services of hospital in community.

No. 28

Presenting Problem: Repeated suicide attempts; setting fire to self.

Diagnosis: Psychoneurosis—with depression.

Previous Interventions: Hospitalization—public psychiatric hospital in community. Hospitalization—private psychiatric hospital in community.

No. 29

Presenting Problem: Chronic drug abuse with repeated overdoses; reactive confusion and deterioration.

Diagnosis: Psychoneurosis with chronic drug abuse.

Previous Interventions: School special services. Counselling in several drug treatment centers. Hospitalization in private psychiatric hospital. Emergency medical treatment for drug overdoses.

No. 30

Presenting Problem: Severe asocial withdrawal; bizarre talk and behavior in the community; inappropriate sexual behavior with exploitation.

Diagnosis: Schizoprhenia of adolescence.

Previous Interventions: School special services.

No. 31

Presenting Problem: Total refusal to eat or drink with life-threatening weight loss and dehydration; lifelong bizarre and nonadaptive behavior.

Diagnosis: Childhood Schizophrenia.

Previous Interventions: Speech therapy — community speech and hearing clinic. Neurological, psychiatric and psychological studies—repeated many times in numerous hospitals and clinics. Day care psychiatric program in community. Placement attempted in several community resources but refused because of behavior.

No. 32

Presenting Problem: Wandering in community with impulsive darting in front of moving cars and similar life-threatening behavior; severe aggressive acting-out at home and in the community; encopresis and enuresis.

Diagnosis: Encephalopathy—severe, chronic. Chronic deprivation and neglect.

Previous Interventions: School special services. Special education classroom in public school. Pediatric wards in community hospitals. Hospitalization in private psychiatric hospital. Protective services in community—numerous agencies. Placement attempted in several community resources but refused because of behavior. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 33

Presenting Problem: Aggressive, physical attacks on younger siblings; fire-setting in the community; inability to attend public school.

Diagnosis: Psychoneourosis with depression. Chronic deprivation and neglect.

Previous Interventions: School special services. Foster home placement—relatives. Placement—in-patient special education program. Juvenile Court intervention. Hospitalization in private psychiatric hospital.

No. 34

Presenting Problem: Asocial withdrawal—severe; unable to attend to personal hygiene needs; sexual acting-out with younger siblings; outbursts of uncontrollable temper.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Special education classroom in public school.

No. 35

Presenting Problem: Obesity, marked, with many serious medical complications; very negative self image and poor interpersonal relationships; academic learning difficulties.

Diagnosis: Psychoneurosis, severe. Dyslexia.

Previous Interventions: Psychotherapy—private practitioner. School special services.

No. 36

Presenting Problem: Severe depression with obsessive preoccupations with death; encopresis.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy in out-patient department of community hospital.

No. 37

Presenting Problem: Acute catatonic state—stupor.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: Family therapy in community mental health clinic. Day care in community psychiatric program. Hospitalization in psychiatric hospital in community.

No. 38

Presenting Problem: Life-long maladaptation with marked anxiety; severe temper tantrums in response to minimal frustration; inability to function in public school.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Special education classroom in public school.

No. 39

Presenting Problem: Very unhappy and uncomfortable child; aggressive attacks on younger sibling; vandalism and stealing.

Diagnosis: Psychoneurosis. Chronic deprivation.

Previous Interventions: Numerous recommendations for help in community rejected by the mother.

No. 40

Presenting Problem: Fire setting in community; much destruction of property; encopresis and enuresis.

Diagnosis: Psychoneurosis. Chronic neglect.

Previous Interventions: Diagnostic studies in several out-patient clinics. Juvenile court interventions. Placement in group care program in community—excluded because of behavior. Day care in psychiatric facility—unable to adjust.

No. 41

Presenting Problem: Sadistic attacks on younger children; threats to stab mother; behavior unmanageable at home and in school.

Diagnosis: Relatively affectionless personality.

Previous Interventions: School special services. Pediatric hospital intervention. Counselling for family in community agency. Hospitalization—emergency admission to psychiatric hospital. Hospitalization—private psychiatric hospital in community.

No. 42

Presenting Problem: Unmanageable at home and at school; sexual acting-out in community; very unhappy and socially uncomfortable child.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy—out-patient clinic in community. Placement—private boarding school—financially prohibitive. Day care in psychiatric facility—failed to adjust.

No. 43

Presenting Problem: Attempted homicide; attempted suicide; fire-setting in community.

Diagnosis: Childhood schizophrenia. Encephalopathy.

Previous Interventions: Hospitalization in community psychiatric hospital. Juvenile Court interventions following attempted homicide and fire-setting. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 44

Presenting Problem: Rage reactions constituting danger at home; generally infantile behavior and very poor peer relationships; uneven developmental pattern.

Diagnosis: Psychoneurosis, severe. Encephalopathy.

Previous Interventions: Diagnostic studies—hospital outpatient clinic. School special services. Family therapy—private practitioner.

No. 45

Presenting Problem: School refusal of more than two-year duration, unresponsive to numerous community intervention efforts.

Diagnosis: Psychoneurosis with severe phobias.

Previous Interventions: School special services. Family therapy in community mental health program.

No. 46

Presenting Problem: Severe rage reactions; physical aggression toward children and adults; unhappy child with extremely poor social skills.

Diagnosis: Psychoneurosis with marked emotional immaturity.

Previous Interventions: School special services. Protective services for family—many community agencies. Juvenile court interventions. Placement in residential group care program in community—excluded because of behavior.

No. 47

Presenting Problem: Suicide attempts; markedly agitated behavior with bizarre rituals and head banging; life-long pattern of maladaptation.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Family therapy in community mental health clinic. Hospitalization in psychiatric unit of community hospital for emergency care.

No. 48

Presenting Problem: Autistic self absorption; bizarre behavior; congenital deafness.

Diagnosis: Childhood schizophrenia. Congenital deafness.

Previous Interventions: School special services. Special education classroom in public school. Diagnostic studies in numerous hospitals and other agencies. Family therapy in community mental health program. Placement in residential program for deaf children attempted but child refused admission because of mental illness.

No. 49

Presenting Problem: Self destructive behavior in reaction to frustration; marked aggression toward peers; unable to adapt in long series of foster homes.

Diagnosis: Encephalopathy with impulse disorder. Marked early neglect and diffusion in care.

Previous Interventions: Juvenile Court interventions. Placement in foster homes; at least seven. Placement in residential group care program in community—excluded because of behavior.

No. 50

Presenting Problem: Bizarre behavior since early childhood; severe asocial withdrawal; limited speech and language development with echolalia.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Diagnostic studies in out-patient clinic of several community hospitals. Family therapy in community mental health center. Day care program in psychiatric facility in community.

No. 51

Presenting Problem: Very negative self image reflected in delinquent acting-out behavior; aggressive attacks on siblings; destruction of personal possessions during rage reactions.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy in community family service agency.

No. 52

Presenting Problem: Violent temper outbursts with minimal provocation; inability to attend school; enuresis—chronic, intractable.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services. Family therapy in community mental health resource.

No. 53

Presenting Problem: Violent temper outbursts; severe academic learning difficulties; impaired motor coordination.

Diagnosis: Encephalopathy, severe with impulse disorder.

Previous Interventions: School special services. Special education classroom in public school. Juvenile Court interventions. Hospitalization in psychiatric hospital in community.

No. 54

Presenting Problem: Bizarre behavior pattern since early childhood; severe asocial withdrawal; speech and language limited to occasional echolalia; repetitive motor mannerisms; uncontrolled striking out when frustrated.

Diagnosis: Childhood Schizophrenia.

Previous Interventions: Day care in special education program in community. Day care in psychiatric hospital program.

No. 55

Presenting Problem: Suicide threats; progressive asocial withdrawal; gradual deterioration in general functioning.

Diagnosis: Psychoneurosis with severe depression.

Previous Interventions: School special services.

No. 56

Presenting Problem: Very unhappy, socially uncomfortable child; chronic negative acting-out behavior including stealing; traumatic sexual experiences.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy in community mental health agency.

No. 57

Presenting Problem: Inability to attend school; very negative self image with poor social skills; enuresis—chronic, intractable.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services.

No. 58

Presenting Problem: Repeated delinquency including breaking and entering; unable to attend school.

Diagnosis: Encephalopathy.

Previous Interventions: Special school services. Family therapy in community mental health agency. Placement in residential group care program—excluded because of behavior.

No. 59

Presenting Problem: Rapid onset of grossly disturbed behavior with hallucinations, delusions, bizarre reactions and "coma".

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: Psychotherapy—private practitioner. Family therapy in community mental health clinic.

No. 60

Presenting Problem: Emergency admission — homicide attempt by setting fire to the family home; set fire to infant sibling's crib with infant in crib; set fire to brother's bed while brother asleep in bed; chronic enuresis.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: None: no alternative to admission at time of referral because of severe emergency situation.

No. 61

Presenting Problem: Marked hypercativity with severe temper tantrums and destructive behavior; physical attacks on younger children.

Diagnosis: Encephalopathy with impulse disorder.

Previous Interventions: School special services. Family therapy in community mental health clinic. Day care in community mental health clinic—unable to adjust.

No. 62

Presenting Problem: Sexual difficulties in community—

transvestism; marked anxiety, social discomfort and desire for help.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: School special services. Family therapy in community mental health agency.

No. 63

Presenting Problem: Fire setting at home and in community; unable to attend school; encopresis and enuresis, chronic intractable.

Diagnosis: Psychoneurosis.

Previous Interventions: Family therapy with private practitioner. School special services. Placement in residential group care program attempted but not possible because of severity of disturbance.

No. 64

Presenting Problem: Sadistic attacks on both children and adults using butcher knives; fire-setting in community.

Diagnosis: Relatively affectionless personality. Chronic deprivation and neglect.

Previous Interventions: Protective service—many community agencies. Family therapy in community mental health agency. Foster homes—all unsuccessful. Juvenile Court intervention. Hospitalization in private psychiatric hospital in community.

No. 65

Presenting Problem: Asocial withdrawal alternating with belligerent acting out; negative self image with very poor peer relationships; unable to attend school.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: School special services. Family therapy in community mental health clinic. Day care in private program in community.

No. 66

Presenting Problem: Epilepsy—mixed seizure pattern; severe temper outbursts; many self destructive threats.

Diagnosis: Epilepsy, chronic, idiopathic. Psychoneurosis with depression.

Previous Interventions: Neurological and psychiatric studies—pediatric hospital in community. School special services.

No. 67

Presenting Problem: Mutism; regressed, primitive, unpatterned behavior.

Diagnosis: Uncertain — question of childhood schizophrenia or encephalopathy with mental retardation.

Previous Interventions: Nursery schools both public and private. Family therapy in community mental health agency. Consultations in community hospital leading to referral to Hawthorn Center.

No. 68

Presenting Problem: Marked hyperactivity with aggressive, destructive acting-out behavior in home, school and community; unhappy child with very negative self percept.

Diagnosis: Psychoneurosis.

Previous Interventions: Family therapy in community mental health agency. Special education in private specialized clinic.

No. 69

Presenting Problem: Physical attacks on younger children including threats with knives; aggressive sexual attacks on younger children; encopresis.

Diagnosis: Encephalopathy, chronic, severe. Chronic deprivation and neglect.

Previous Interventions: School special services. Family therapy in community mental health agency. Diagnostic studies in hospital out-patient clinic. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 70

Presenting Problem: Sadistic behavior directed toward younger children; fire-setting—baby's crib—baby in crib; urination and defecation in closets at home and at school; aggressive play with knives, matches and axes; very unhappy, severely rejected child.

Diagnosis: Psychoneurosis. Severe neglect.

Previous Interventions: School special services. Special education classroom in public school. Day care in community mental health program.

No. 71

Presenting Problem: Fire-setting in community; severely impulsive aggressive behavior; functional blindness — familial.

Diagnosis: Encephalopathy, severe. Chronic deprivation and neglect.

Previous Interventions: School special services. Special education class in public school—excluded. Pediatric service, community hospital — ophthalmology and neurology studies and treatment. Juvenile Court intervention. Hospitalization in private psychiatric hospital in community.

No. 72

Presenting Problem: Suicide attempt — drug overdose; severe chronic depression; marked anxiety in reaction to sexual identity problems.

Diagnosis: Psychoneurosis, with severe depression.

Previous Interventions: Psychotherapy—private practitioner.

No. 73

Presenting Problem: Epilepsy, psychomotor; severely aggressive destructive episodes; threatening safety of others.

Diagnosis: Epilepsy, psychomotor.

Previous Interventions: School special services. Neurological studies—numerous in several hospital clinics. Special education therapy in community program.

No. 74

Presenting Problem: Severe acting-out behavior with much kicking and screaming; bizarre thought content; unable to attend school.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Special school services. Day school, private: excluded because of behavior. Family therapy in community-private practitioner. Hospitalization in psychiatric unit of hospital in community.

No. 75

Presenting Problem: Suicidal preoccupations and threats; victim of sexual molestation; beginning anorexia.

Diagnosis: Psychoneurosis with severe depression.

Previous Interventions: None known.

No. 76

Presenting Problem: Bizarre, aggressive and life-threatening behavior; suicide attempt—drug overdose; sexually exploited in community.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: School special services. Special education classroom. Hospitalizations in four psychiatric or pediatric hospitals. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 77

Presenting Problem: Severe temper outbursts with minimal provocation; academic learning difficulties; unable to attend public school; very negative self image with poor peer relationships.

Diagnosis: Encephalopathy with impulse disorder. Psychoneurosis. Dyslexia.

Previous Interventions: School special services. Family therapy—hospital out-patient clinic in community. Private tutoring in community.

No. 78

Presenting Problem: Increasingly pervasive suicide preoccupations and threats; severe depression; asocial withdrawal.

Diagnosis: Phychoneurosis, with severe depression.

Previous Interventions: Psychotherapy in community—private practitioner.

No. 79

Presenting Problem: General deterioration in adjustment; increasingly aggressive, unmanageable behavior; very negative self image.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Special classroom in public school. Family therapy in community mental health agency.

No. 80

Presenting Problem: Encopresis, severe, intractable with fecal retention and secondary bowel pathology.

Diagnosis: Psychoneurosis.

Previous Interventions: Family therapy in community mental health agency.

No. 81

Presenting Problem. Acute psychosis probably induced by drug abuse; delusions of omnipotence with bizarre threatening behavior; emergency admission to hospital indicated.

Diagnosis: Acute psychosis probably toxic.

Previous Interventions: None — at the time of referral there was no alternative to hospitalization. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 82

Presenting Problem: Juvenile diabetes with suicide preoccupations and attempts; refusal to cooperate in diabetes treatment regime, attempting to induce diabetic coma with suicide intent.

Diagnosis: Juvenile diabetes. Psychoneurosis with severe depression.

Previous Interventions: Diagnostic studies — private practitioner in community. Family therapy in out-patient clinic of community hospital. Crisis center in community hospital for suicide attempt.

No. 83

Presenting Problem: Severe asocial withdrawal since early childhood; no speech or language for communications; severe temper outbursts with destructive behavior and fire-setting; unable to attend public school.

Diagnosis: Childhood Schizophrenia.

Previous Interventions: Diagnostic studies in out-patient clinic of community hospital. Nursery school in community. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 84

Presenting Problem: Inability to eat with life-threatening weight loss; bizarre exercise patterns; repeated suicide threats; suicide attempt.

Diagnosis: Anorexia Nervosa, severe.

Previous Interventions: Psychotherapy — private practitioner in community.

No. 85

Presenting Problem: Somatic complaints — numerous, disabling; negative self image and poor peer relationships; frequently unable to attend school; chronic academic underachievement.

Diagnosis: Psychoneurosis with depression. Encephalopathy.

Previous Interventions: School special services. Special education classroom in public school. Juvenile Court interventions. Family protective services in community.

No. 86

Presenting Problem: Diffuse, disorganized behavior since infancy; very limited speech and language development; severe asocial withdrawal.

Diagnosis: Encephalopathy, severe.

Previous Interventions: Diagnostic studies in several hospital out-patient clinics. Speech and hearing therapy in community clinic. Day care in two special education programs in community.

No. 87

Presenting Problem: Aggressive outbursts threatening safety; marked hyperactivity; uneven growth pattern with reactive anxiety and social discomfort.

Diagnosis: Encephalopathy. Psychoneurosis.

Previous Interventions: School special services. Special education classroom in public school. Family therapy in community mental health agency.

No. 88

Presenting Problem: Almost total asocial withdrawal since infancy; impulsive sadistic acting out since age 2 years; no speech or language development.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Diagnostic studies in out-patient clinics of several hospitals in community. Protective services in community. Nursery school in community — excluded because of behavior. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 89

Presenting Problem: Sexual acting-out in community — attacks on younger children; chronic severe delinquency including breaking and entering; fire-setting.

Diagnosis: Psychoneurosis, severe. Chronic deprivation and neglect.

Previous Interventions: School special services. Juvenile Court interventions. Placement in residential group care setting in community — excluded because of behavior.

No. 90

Presenting Problem: Self imposed starvation with life threatening weight loss; inability to attend school for more than four months; progressive deterioration in general health.

Diagnosis: Anorexia Nervosa.

Previous Interventions: Pediatric interventions — intensive measures. Psychotherapy, intensive, in hospital out-patient clinic.

No. 91

Presenting Problem: Bizarre behavior since early childhood; idiosyncratic speech pattern with echolalia; severe temper outbursts with minimal provocation; many rituals including long periods of head banging.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Special education classroom in public school — excluded. Day care special education program in community — excluded because of behavior. Day care in community mental health program.

No. 92

Presenting Problem: Severe depression with inertia; inability to attend school; suicide preoccupation.

Diagnosis: Psychoneurosis, severe; Obsessive-compulsive.

Previous Interventions: Family therapy in psychiatric hospital out-patient clinic. Psychotherapy — private practitioner. Family therapy in community mental health clinic.

No. 93

Presenting Problem: Aggressive, destructive, threatening behavior at home, in school and in community; Chronic delinquency with stealing and vandalism; primitive behavior such as defecating in closets.

Diagnosis: Psychoneurosis. Chronic deprivation and neglect.

Previous Interventions: School special services. Juvenile Court interventions. Hospitalization in private psychiatric hospital in community. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 94

Presenting Problem: Suicide attempt during rage reaction; severe temper outbursts with head banking; unable to attend public school.

Diagnosis: Encephalopathy with borderline mental retardation.

Previous Interventions: School special services. Juvenile Court interventions. Placements: four foster homes — excluded from all because of behavior. Placement: Residential special education program — excluded because of behavior.

No. 95

Presenting Problem: Severe, chronic aggression impairing all relationships and placements; marked hyperactivity and lack of impulse control.

Diagnosis: Encephalopathy with impairment in academic learning. Early deprivation and neglect.

Previous Interventions: Placements: series of foster homes — excluded from all because of behavior. Juvenile Court interventions. Placement in residential group care program in community — unable to adjust.

No. 96

Presenting Problem: Very negative self image and personal discomfort; uncontrollable temper outbursts with threats to safety; marked social isolation and rejection; academic failure despite very high potential.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services. Family therapy in community mental health agency. Placement in residential group care program in community — unable to adjust.

No. 97

Presenting Problem: Asthma — chronic, severe with marked anxiety; encopresis and enuresis; very poor impulse control; very uncomfortable in all areas of adaptation.

Diagnosis: Psychoneurosis with bronchial asthma.

Previous Interventions: Pediatric intervention over period of years. School special services. Family therapy — private practitioner. Family therapy in hospital out-patient clinic.

No. 98

Presenting Problem: Suicide attempt following repeated threats; profound general discouragement.

Diagnosis: Psychoneurosis, severe depression.

Previous Interventions: School special services. Placement: foster home in community — unsuccessful. Placement: residential group care program in community. Placement: second residential group care program in community. Psychotherapy, emergency care, crisis-suicide center in community hospital.

No. 99

Presenting Problem: Chronic aggressive behavior impairing adjustment at home, in school and in the community.

Diagnosis: Psychoneurosis. Chronic deprivation and neglect.

Previous Interventions: School special services. Family therapy — private practitioner in community.

No. 100

Presenting Problem: Numerous disabling fears, including fear of attack from dead relatives; inability to eat because of fear that food is poisoned; hallucinations with reactive attacks on peers — knives and scissors.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: School special services. Family therapy in out-patient clinic of hospital in community. Hospitalization in public psychiatric hospital.

No. 101

Presenting Problem: Gradual deterioration in adjustment at all levels; inability to attend public school or special day school in community; severe anxiety and social discomfort.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Family therapy — private practitioner in community. Day care in psychiatric program in community.

No. 102

Presenting Problem: Post-traumatic regression and impulsivity — head injury with coma; severe temper outbursts; fire-setting in community.

Diagnosis: Encephalopathy, post-traumatic.

Previous Interventions: Pediatric intervention over long period. Family therapy — private practitioner in community. Placement: In foster home — unsuccessful. Hospitalization in private psychiatic hospital.

No. 103

Presenting Problem: Fire-setting at home and in community; chronic enuresis; aggressive outbursts interferring with all relationships.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy in community mental health clinic. Placement in private boarding school — excluded because of behavior. Hospitalization in public psychiatric hospital.

No. 104

Presenting Problem: Acute onset of markedly bizarre behavior with delusions; unable to sleep, disoriented, agitated; picked up by police because of bizarre behavior in the community.

Diagnosis: Schizophrenia of adolescence.

Previous Interventions: School special services. Family therapy in outpatient clinic of psychiatric hospital. Hospitalization in psychiatric unit of community hospital. Hospitalization in private psychiatric hospital.

No. 105

Presenting Problem: Impulsive aggressive behavior impairing adaptation in all areas; severe temper outbursts in response to minimal frustration; marked unhappiness and negative self percept.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: Family therapy in community mental health program. Psychotherapy — private therapist in the community.

No. 106

Presenting Problem: Self mutilation attempts — castration; severe depression with increasing preoccupation with harm to self.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Pediatric emergency care for self mutilation. Hospitalization in public psychiatric hospitals—two hospitals. Hospitalization in private psychiatric hospital. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 107

Presenting Problem: Profound regression in all areas of

function; self mutilation, chronic, severe; loss of all meaningful speech; severe asocial withdrawal.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Pediatric interventions in hospital out-patient clinic. Family therapy in community mental health agency. Counselling in community parents' association. Day care in community psychiatric program.

No. 108

Presenting Problem: Fire-setting in community with severe danger to life; admitted for emergency study.

Diagnosis: Psychoneurosis. Dyslexia.

Previous Interventions: School special services. Speech therapy in community clinic. Tutoring—remedial reading in community.

No. 109

Presenting Problem: Encopresis—chronic, intractable; general emotional immaturity with marked social incompetence.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: Pediatric intervention—unsuccessful. School special services.

No. 110

Presenting Problem: Aggressive acting-out behavior impairing adjustment at home, in school and in community; chronic underachievement in school with reactive anxiety and depression.

Diagnosis: Encephalopathy—post-encephalitis. Phychoneurosis with depression.

Previous Interventions: School special services. Diagnostic studies—four studies in community agencies. Pediatric interventions, intensive.

No. 111

Presenting Problem: Fire-setting in community; sexual acting-out with younger children; severe behavior problem at home, in school and in the community; very severe academic learning difficulties.

Diagnosis: Psychoneurosis, severe. Dyslexia, severe.

Previous Interventions: School special services. Family therapy in community mental health clinic. Family therapy —private practitioner in the community.

No. 112

Presenting Problem: Chronic pattern of poor adjustment and need for much special help in all areas; impulsive acting-out behavior impairing all relationships.

Diagnosis: Relatively affectionless personality. Chronic deprivation and neglect.

Previous Interventions: Placements: Several foster homes. Protective services in community—many agencies. Family therapy in hospital outpatient clinic. Juvenile Court interventions. Placement in residential group care program in community—excluded because of behavior.

No. 113

Presenting Problem: Fire-setting in community; uncontrollable temper outbursts with threats to safety.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: School special services. Juvenile Court intervention. Family therapy in two community mental health programs.

No. 114

Presenting Problem: Aggressive, destructive acting-out behavior at home, in school and in the community; hyperactivity interferring with adjustment in all areas.

Diagnosis: Encephalopathy with impulse disorder. Psychoneurosis with anxiety.

Previous Interventions: School special services. Special education classroom in public school. Therapy in community special education program. Pediatric intervention, including neurological studies, over several years.

No. 115

Presenting Problem: Fire-setting in the community; hair pulling, chronic; severe night terrors and sleep walking.

Diagnosis: Psychoneurosis, severe.

Previous Interventions: School special services. Diagnostic studies in two hospital programs. Day care in psychiatric treatment program.

No. 116

Presenting Problem: Very unhappy in all relationships, including very negative self percept; reactive, hostile and aggressive behavior at home and at school; severe academic learning problems.

Diagnosis: Psychoneurosis, severe. Dyslexia.

Previous Interventions: School special services. Family therapy in community mental health clinic. Family therapy in psychiatric hospital outpatient clinic.

No. 117

Presenting Problem: Encopresis and enuresis, chronic, intractable; obesity; severe problems in academic learning; marked emotional immaturity.

Diagnosis: Psychoneurosis, severe. Dyslexia.

Previous Interventions: School special services. Special education classroom in public schools.

No. 118

Presenting Problem: Asocial withdrawal and bizarre preoccupations and behavior; unable to participate in group activities; very poor relationships with peers; unable to attend school periodically.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Family therapy in community mental health program. Family therapy in second community mental health program.

No. 119

Presenting Problem: Fire-setting in community; encopresis and enuresis, chronic; self mutilation with primitive acting-out behavior.

Diagnosis: Relatively affectionless personality. Chronic deprivation and neglect.

Previous Interventions: Pediatric interventions. School special services. Family therapy in community mental health clinic. Special education therapy in community program.

No. 120

Presenting Problem: Suicide attempt; chronic depression with frequent crying spells, uncontrolled; inability to sleep.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: School special services. Family therapy in community mental health program.

No. 121

Presenting Problem: Aggressive acting-out behavior impairing relationships at all levels; very negative self image with reactive anxiety and discomfort.

Diagnosis: Encephalopathy. Psychoneurosis.

Previous Interventions: School special services. Family therapy in community mental health clinic.

No. 122

Presenting Problem: Suicide preoccupations reactive to death in family; poor academic achievement with reactive counter-aggression, impairing relationships.

Diagnosis: Psychoneurosis with depression. Dyslexia.

Previous Interventions: School special services.

No. 123

Presenting Problem: Very unhappy child, reacting with chronic delinquent behavior; severe sleep disturbance; severe underachievement at school.

Diagnosis: Psychoneurosis with depression.

Previous Interventions: Family therapy in community out-patient treatment program.

No. 124

Presenting Problem: Very negative self image with reactive chronic negative, acting-out behavior; severe temper tantrums; obese; enuretic.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services.

No. 125

Presenting Problem: Suicide attempt—drug overdose; long history of hysterical acting-out episodes; previous suicide attempts.

Diagnosis: Psychoneurosis with hysteria.

Previous Interventions: School special services. Family therapy in community mental health agency. Placement in residential group care program stressing special education—excluded because of behavior. Hospitalization—community hospital: emergency care following suicide attempts. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 126

Presenting Problem: Very unhappy child, reacting with chronic aggressive behavior; encopresis, chronic; severe academic underachievement.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services. Family therapy—private practitioner in community.

No. 127

Presenting Problem: Chronic aggressive acting-out behavior; negative self image interferring with all relationships.

Diagnosis: Psychoneurosis.

Previous Interventions: Diagnostic studies in two hospital out-patient departments — psychiatric. School special services. Remedial tutoring in private clinic in community. Placement in private boarding school — excluded because of behavior.

No. 128

Presenting Problem: Fire-setting in community; inability to adapt in adoptive home with reactive severe acting-out behavior; inability to attend public school; moderately severe hearing loss, post-rubella.

Diagnosis: Psychoneurosis with very negative self-image.

Previous Interventions: Family therapy in community family service agency. Placement in residential group care program in community.

No. 129

Presenting Problem: Primitive disorganized behavior reactive to life-long rejection; enuresis, chronic; marked hyperactivity with aggressive acting-out and destructiveness.

Diagnosis: Relatively affectionless personality. Chronic deprivation and neglect.

Previous Interventions: Juvenile Court involvement. Placements in at lease seven foster homes—all unsuccessful. Placement in residential group care program in community — excluded because of behavior.

No. 130

Presenting Problem: Severe reactive depression following desertion by mother; suicide preoccupations and threats; epilepsy.

Diagnosis: Psychoneurosis, reactive depression. Epilepsy.

Previous Interventions: Juvenile Court interventions. Diagnostic studies in community hospital out-patient clinic. Placement in home of relative — unsuccessful. Placement in agency foster home — unsuccessful. Psychotherapy in community mental health program.

No. 131

Presenting Problem: Unmanageable behavior at home and at school with many threats of violence; involvement in drug abuse with reactive confusional states.

Diagnosis: Psychoneurosis.

Previous Interventions: Family therapy in community mental health clinic. Psychotherapy in hospital out-patient clinic. Efforts to find group placement in community unsuccessful.

No. 132

Presenting Problem: Fire-setting in community with great danger to safety; emergency admission indicated and implemented.

Diagnosis: Psychoneurosis, chronic. Chronic deprivation and neglect.

Previous Interventions: Juvenile Court Intervention. Psychotherapy in community family service agency. Placements in long series of foster homes with numerous replacements necessary.

No. 133

Presenting Problem: Very negative self image with reactive uncontrolled aggressive behavior at home, in school and in community; very low academic achievement; marked emotional immaturity.

Diagnosis: Psychoneurosis. Dyslexia.

Previous Interventions: School special services. Special education in classroom in public school. Family therapy in community family service agency.

No. 134

Presenting Problem: Obesity with reactive negative self percept and acting-out behavior; marked emotional immaturity; negative behavior alienating peers and impairing all relationships.

Diagnosis: Psychoneurosis.

Previous Interventions: Family therapy — private practitioner in community. School special services. Hospitalization in psychiatric unit of community hospital.

No. 135

Presenting Problem: Emergency admission: dangerous physical attack on younger child; fire-setting in community.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services.

No. 136

Presenting Problem: Negative self image with reactive severe acting-out behavior; unmanageable at home with progressive deterioration in total adjustment; involvement in drug abuse.

Diagnosis: Psychoneurosis.

Previous Interventions: School special services. Counselling in local community agency.

No. 137

Presenting Problem: Negative, destructive and threatening behavior at home, in school and in community; negative self image with reactive counteraggression.

Diagnosis: Psychoneurosis. Early deprivation and neglect.

Previous Interventions: School special services. Family therapy in community mental health clinic. Family therapy in out-patient clinic of community hospital. Placement attempted in residential group care programs in community — admission refused because of severity of behavior problems.

No. 138

Presenting Problem: Violent temper outbursts reactive to minimal frustration; marked hyperactivity; ritualistic, inappropriate, compulsive behavior.

Diagnosis: Encephalopathy. Chronic deprivation and neglect.

Previous Interventions: Juvenile Court interventions. Placements in a series of foster homes. Diagnostic studies in out-patient clinic of two psychiatric hospitals. In special education classroom of public school.

No. 139

Presenting Problem: Dwarfism with reactive depression and great discouragement; hyperactivity with poor impulse control.

Diagnosis: Endocrine dyscrasia with dwarfism. Chronic deprivation and neglect.

Previous Interventions: Pediatric intervention — endocrinology clinics. School special services. Family counselling in out-patient clinic of psychiatric hospital.

No. 140

Presenting Problem: Suicide attempt — drug overdose; involvement in drug abuse; depression with reactive acting-out behavior.

Diagnosis: Psychoneurosis — depression.

Previous Interventions: School special services. Family therapy in community family service agency.

No. 141

Presenting Problem: Bizarre behavior, from early childhood; marked asocial withdrawal alternating with episodes of excitement; idiosyncratic language; unable to attend school in community.

Diagnosis: Childhood schizophrenia.

Previous Interventions: School special services. Family therapy in community mental health agency. Hospitalization in psychiatric hospital in community.

No. 142

Presenting Problem: Suicide threats; fire-setting in community; hyperactive, impulsive, often uncontrolled behavior.

Diagnosis: Encephalopathy with impulse disorder. Chronic deprivation and neglect.

Previous Interventions: Family therapy in community mental health agency. Placement in residential group care program with stress of special education — excluded because of behavior. Placements: numerous foster homes and relatives' homes — all unsuccessful.

No. 143

Presenting Problem: Impulsive, negative acting-out behavior at home, in school and in community; negative self percept with marked emotional immaturity.

Diagnosis: Psychoneurosis — emotional immaturity.

Previous Interventions: Diagnostic studies in psychiatric hospital out-patient clinic. Special education classroom in private day school. Family therapy—private practitioner in community.

No. 144

Presenting Problem: Bizarre, unpredictable behavior such as darting in front of moving cars; attempts at self mutilation; unable to attend public shcool.

Diagnosis: Childhood schizophrenia.

Previous Interventions: Diagnostic studies in several community mental health clinics. Diagnostic studies by several private practitioners in community. Family therapy in community mental health clinic. Day care in community psychiatric day care program.

No. 145

Presenting Problem: Severely aggressive and destructive outbursts with minimal provocation; violence directed toward younger children, with severe threat to safety.

Diagnosis: Psychoneurosis.

Previous Interventions: Juvenile Court Involvements. Family counselling in out-patient clinic of community hospital. Placement in private psychiatric hospital. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 146

Presenting Problem: Asocial withdrawal alternating with episodes of aggressive acting-out; strong feelings of rejection with reactive negativism; marked academic underachievement.

Diagnosis: Psychoneurosis with depression. Encephalopathy.

Previous Interventions: Diagnostic studies in out-patient clinic of community hospital. School special services.

No. 147

Presenting Problem: Uncontrollable rages at home, in school and in community; unable to attend public school; total illiteracy.

Diagnosis: Encephalopathy, with impulse disorder. Dyslexia, severe. Chronic deprivation and neglect.

Previous Interventions: School special services. Special education classroom in public school. Protective services — many community agencies. Family therapy in psychiatric hospital out-patient clinic in community. Hospitalization in psychiatric unit of community hospital.

No. 148

Presenting Problem: Sadistic attacks on younger children and animals; chronic destructive acting-out behavior impairing adjustment at every level; inability to adjust in numerous placements in the community.

Diagnosis: Relatively affectionless personality. Chronic deprivation and neglect.

Previous Interventions: Juvenile Court interventions. Placements in numerous foster homes — all unsuccessful. Hospitalization in psychiatric hospital in community. Placement in residential group care program in community — excluded because of behavior. Hospitalization in private psychiatric hospital in community.

No. 149

Presenting Problem: Very violent impulsive behavior with physical assult on peers and adults; unable to attend public school; anxious and frightened in reaction to lack of impulse control.

Diagnosis: Encephalopathy, severe, with impulse disorder.

Previous Interventions: School special services. Special education classroom in public school. Family therapy in community mental health agency. Hospitalization in children's unit of psychiatric hospital.

MICHIGAN MENTAL HEALTH CODE

Formal Voluntary Admission Provisions

MSA 14.800(415)—(420)

MCLA 330.1415—.1420

Sec. 415(1) An individual 18 years of age or over may be hospitalized as a formal voluntary patient if he executes an application for hospitalization as a formal voluntary patient and if the director of the hospital deems him clinically suitable for that form of hospitalization.

(2) An individual less than 18 years of age may be hospitalized as a formal voluntary patient if an application for his hospitalization as a formal voluntary patient is executed by his parent, guardian, or, in the absence of his parent or guardian, a person in loco parentis, and if the director of the hospital deems him clinically suitable for that form of hospitalization.

Sec. 416 The formal application shall contain in large type and simple language the substance of sections 417 to 420. Upon hospitalization, the rights set forth in the application shall be orally communicated to the patient and

to the person who executed the application. In addition, a copy of the application shall be given to each of the aforementioned persons and to one other person designated by the patient.

Sec. 417(1) Objection may be made to the hospitalization of a minor of any age under section 415(2). Objections may be filed with the court by a person found suitable by the court or by the patient himself if he is at least 13 years of age. The objection shall be made in writing to the court not more than 30 days after hospitalization of the patient, and may be made subsequently at any 3-month interval following the date of the original objection or, if an original objection was not made, at any 3-month interval following the date of hospitalization.

(2) If the patient informs the hospital that he desires to object to his hospitalization, the hospital shall assist him in properly submitting the objection to the court.

(3) Upon receipt of an objection, the court shall schedule a hearing to be held within 7 days, excluding Sundays and holidays. The court shall notify the objecting person, the patient, the person who executed the application, and the director of the hospital of the time for the hearing.

(4) The hearing shall be governed by those provisions of sections 451 to 465, including the appointment of counsel and an independent medical evaluation, which the court deems necessary to ensure that all pertinent information is brought to its attention, and by the provisions of this section.

(5) Unless the court sustains the objection and orders the discharge of the patient, the hospital may continue to hospitalize the patient, no court order shall be entered, and the objection shall be terminated.

(6) The court shall sustain the objection and order the discharge of the patient if the patient is not in need of the treatment which is available at the hospital or if a treatment program which does not involve hospitalization is available and appropriate for the patient.

(7) Unwillingness or inability of the parent, guardian, or person in loco parentis to provide for the management, care, or residence of the patient shall not be grounds for refusing to sustain the objection and order discharge, but in that event the objecting person may, or a person authorized by the court shall, promptly file a petition under the neglect provisions of the juvenile code to ensure that appropriate management, care, or residence is provided.

Sec. 418 If a hospital has officially agreed to hospitalize a minor, but hospitalization has been deferred until a subsequent date, an objection to hospitalization of the minor may be made prior to hospitalization of the minor and shall be governed by section 417. If the objection is sustained by the court, the minor shall not be hospitalized.

Sec. 419(1) Except as is provided in section 420, a formal voluntary patient 18 years of age or over shall not be hospitalized more than 3 days, excluding Sundays and holidays, after he gives written notice of his intention to terminate his hospitalization and leave the hospital.

(2) Except as is provided in section 420, a formal voluntary patient less than 18 years of age shall not be hospitalized more than 3 days, excluding Sundays and holidays, after his parent, guardian, or person in loco parentis gives written notice of his intention to terminate the hospitalization and to remove the patient from the hospital.

(3) When the hospital is told of an intention to terminate hospitalization under subsection (1) or (2), it shall promptly supply the written form which is required.

Sec. 420 If a written notice of termination of hospitalization is given to a hospital under section 419, if the notice is not withdrawn, and if the director determines that the patient is a person requiring treatment as defined in section 401 and should remain in the hospital, the director or other suitable person shall within 3 days, excluding Sundays and holidays, of the hospital's receipt of the notice file an application with the court which complies with section 423. The application shall be accompanied by the certificates of 2 physicians, at least one of whom shall be a psychiatrist. If an application is filed, the hospital may continue hospitalization of the patient pending hearings convened pursuant to sections 450 to 456.